

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03071

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03058

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 8 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 216 Charles Street		e. STREET ADDRESS 216 Charles Street	
3. NAME OF DECEASED (Type or print) First William Middle Howard Last Alderton		4. DATE OF DEATH Month March Day 10 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 1, 1913
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 66 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager of Food Market		11b. KIND OF BUSINESS OR INDUSTRY Cumberland Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Cecil Alderton	
14. MOTHER'S MAIDEN NAME Bertie Troutman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-05-8864		17. INFORMANT Mrs. Georgia Alderton Address 216 Charles St Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201			INTERVAL BETWEEN ONSET AND DEATH Sudden -----
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED March 10, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/12/66	
23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens		23d. LOCATION (City or Town) (County) (State) LaVale Allegany Maryland	
24. FUNERAL DIRECTOR Ruth E. Silcox ADDRESS Cumberland Maryland 21502		25a. REC'D BY REGISTRAR MAR 14 1966	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

10000

10000

25b. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 21 1966 Charles Judge

03080

03080

03080

03080

03080

03080

03080

03080

03080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03073					03060				
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 1602 HOLLAND ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last F. GILLBERT BECKER			4. DATE OF DEATH Month Day Year MARCH 15 1966		5. SEX MALE				
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 22, 1913		9. AGE (In years last birthday) 52		10. FUNERAL 1 YEAR 11. FUNERAL 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR			10b. KIND OF BUSINESS OR INDUSTRY BREWERY		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CASPER BECKER			14. MOTHER'S MAIDEN NAME ELMAR HOLLENBERGER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2			16. SOCIAL SECURITY NO. 214 05 4969		17. INFORMANT Address MEMORIAL HOSPITAL				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Subarachnoid Hemorrhage due to 3304 DUE TO spontaneous rupture of aneurysm (b) of anterior communicating artery. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None								INTERVAL BETWEEN ONSET AND DEATH 34 hours	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from March 14 4:12 P.M. 3-15-1966 , that (I) (we) last saw the deceased alive on 3-15-1966 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE DR. WYAND F. DOERNER JR.			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-18-66				
22c. PHYSICIAN'S NAME (Type) DR. WYAND F. DOERNER JR.			22d. ADDRESS 414 N. MECHANIC ST. CUMB. MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 18, 1966		23c. NAME OF CEMETERY OR CREMATORY HILB CREST BURIAL PARK		23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.			
24. FUNERAL DIRECTOR BYRON KIGHT			ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR MAR 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

03000

03073

ALLIANCE

CUMBERLAND

1 DAY

1502 HOLLAND ST

MEMORIAL HOSPITAL

MARCH 12

SEEN

CLUB

JULY 27, 1913

WIFE

CUMBERLAND, MD.

ELMAR HOLLERBERGER

DEPT. 2000

MEMORIAL HOSPITAL

2000

1:12 P.M.

DR. WYAND F. GOSWAMI JR. 414 N. MECHANIC ST. CUM. MD.

MAR 2 1922

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03074

CERTIFICATE OF DEATH

03061

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 10 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS BOX323	
3. NAME OF DECEASED (Type or print) First Middle Last ANNAMARY CATHERINE BEVERS		4. DATE OF DEATH Month Day Year MARCH 26 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-91
9. AGE (In years last birthday) yrs. 74		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) MT. SAVAGE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME THOMAS CARABINE	
14. MOTHER'S MAIDEN NAME ANNA RAHRIG		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 218-07-8939		17. INFORMANT PATIENT'S CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Tachycardia 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) ATHEROSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH 2 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes on and on the date stated above.	
22a. SIGNATURE L. Michael Glick M.D.		22b. DATE SIGNED 27 Mar 66	
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK, MD.		22d. ADDRESS 126 N. SMALLWOOD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-29-66	
23c. NAME OF CEMETERY OR CREMATORY ST. PATRICK'S CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.		25a. REC'D BY REGISTRAR DATE MAR 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10080

RECEIVED BY MAIL

37080

DEPT. OF AGRICULTURE

UNITED STATES

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03075 CERTIFICATE OF DEATH 03062											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 208 GRAND AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) IRVIN C. BRANT			4. DATE OF DEATH MARCH 19 1966			5. SEX MALE			6. COLOR OR RACE WHITE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH MAY 20, 1891			9. AGE (In years last birthday) 74 yrs.			IF UNDER 1 YEAR: Months 01 Days 1 IF UNDER 24 HRS: Hours 01 Min. 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber-Retired			10b. KIND OF BUSINESS OR INDUSTRY Self Employed			11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME THEODORE BRANK						14. MOTHER'S MAIDEN NAME CATHERINE BEECHE (Bechy)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT MEMORIAL HOSPITAL			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Immediate Days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland City, Md.			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3/19/66 7:05 P.M. 3/19/66 19 , that (I) (we) last saw the deceased alive on 3/19/66 19 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE DR. R. J. WILLIAMS						22b. DATE SIGNED 3/20/66			22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		
22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD			22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD			22g. REC'D BY REGISTRAR Charles Judge		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-22-1966			23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION (City, town or county) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR Charles Judge					
25b. REGISTRAR'S SIGNATURE Charles Judge						25c. DATE MAR 22 1966					

02008

02008

WILSON

WILSON

WILSON

CHURCH

CHURCH

CHURCH

200 BROAD AVE.

200 BROAD AVE.

CHURCH

CHURCH

CHURCH

MAY 20, 1951

MAY 20, 1951

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

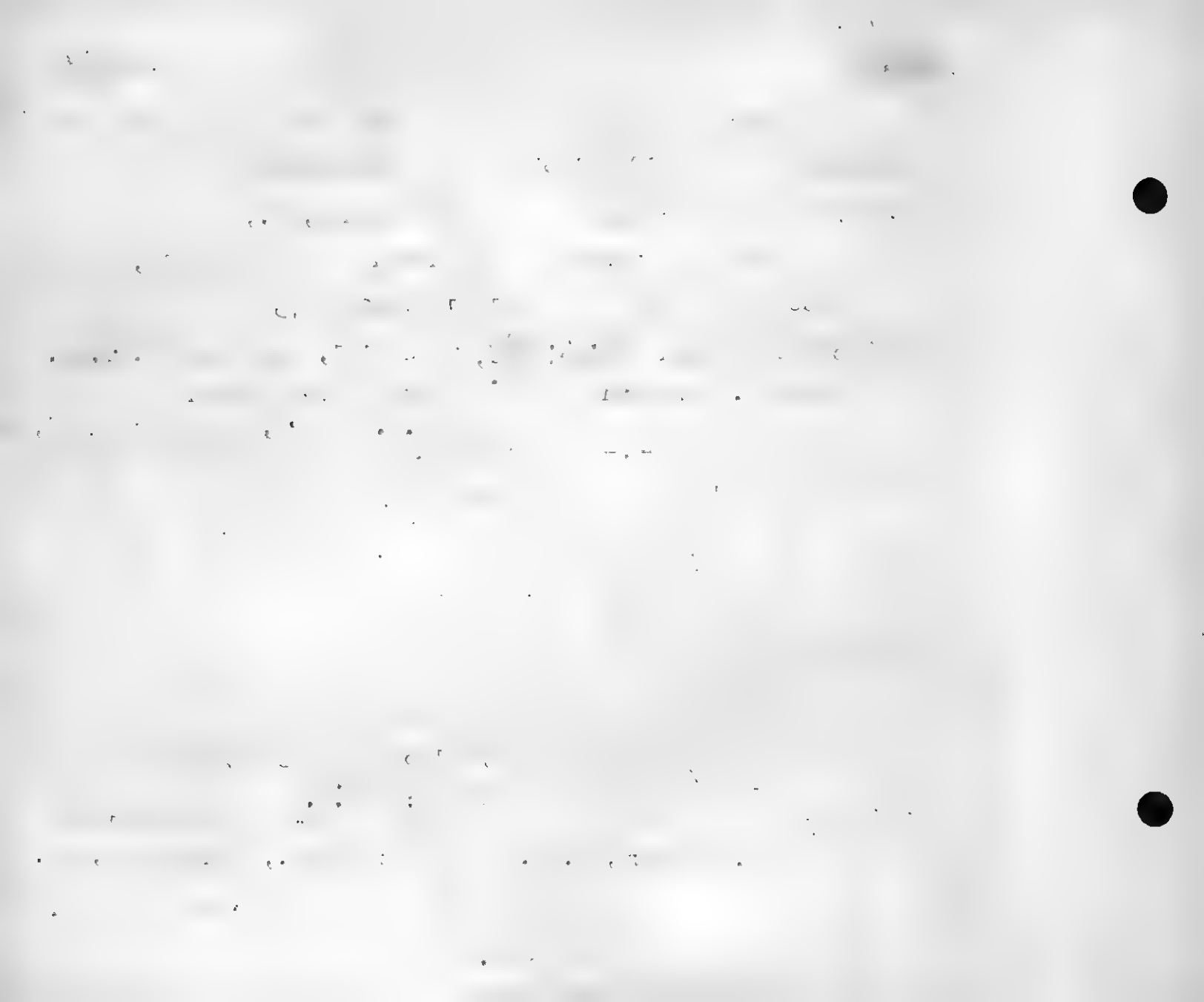
CHURCH

CHURCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and then, event, within 72 hours after death.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 12 DAYS		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL						d. STREET ADDRESS 6-JANE FRAZIER VILLAGE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mary Middle Cecelia Last BROWN			4. DATE OF DEATH Month MARCH Day 23 Year 19 66								
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-13-1885		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) OHIO Belaire			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM TRAPP						14. MOTHER'S MAIDEN NAME MARY Tighe					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Disease 4x1x1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cerebral Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus - Chronic INTERVAL BETWEEN ONSET AND DEATH 1 Hour											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1956 , 19 to 1966 , 19, that (I) (we) last saw the deceased alive on 3/23/66 , 19, and that death occurred at 9:55 PM from the causes and on the date stated above.											
22a. SIGNATURE DR. G. O. HIMMELWRIGHT						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT						22d. ADDRESS 133 VIRGINIA AVE.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/26/66		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City, town or county) (State) Cumberland, Maryland				
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland						25a. REC'D BY REGISTRAR MAR 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coffin papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02078

03065

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>15 So. Centre St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Allen</u> Middle <u>Francis</u> Last <u>Cage</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1903</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. Rwy.</u>		11. BIRTHPLACE (State or foreign country) <u>Brunswick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Newton Cage</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Dyche</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Cora M. Cage 15 So. Centre St. Cumb. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive Arteriosclerosis</u> DUE TO (c) <u>Ischemic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>About 2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Grand Mal</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10-27-1957</u> to <u>3-27-1966</u> , that I last saw the deceased alive on <u>1-6-1966</u> and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. F. Williams</u>				ADDRESS (Street, city or town, state) <u>122 So. Centre St.</u>			
DATE SIGNED <u>3-28-66</u>							
PHYSICIAN'S NAME (Type) <u>W. F. Williams, M.D.</u>				Cumberland, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>				ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 30 1966</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

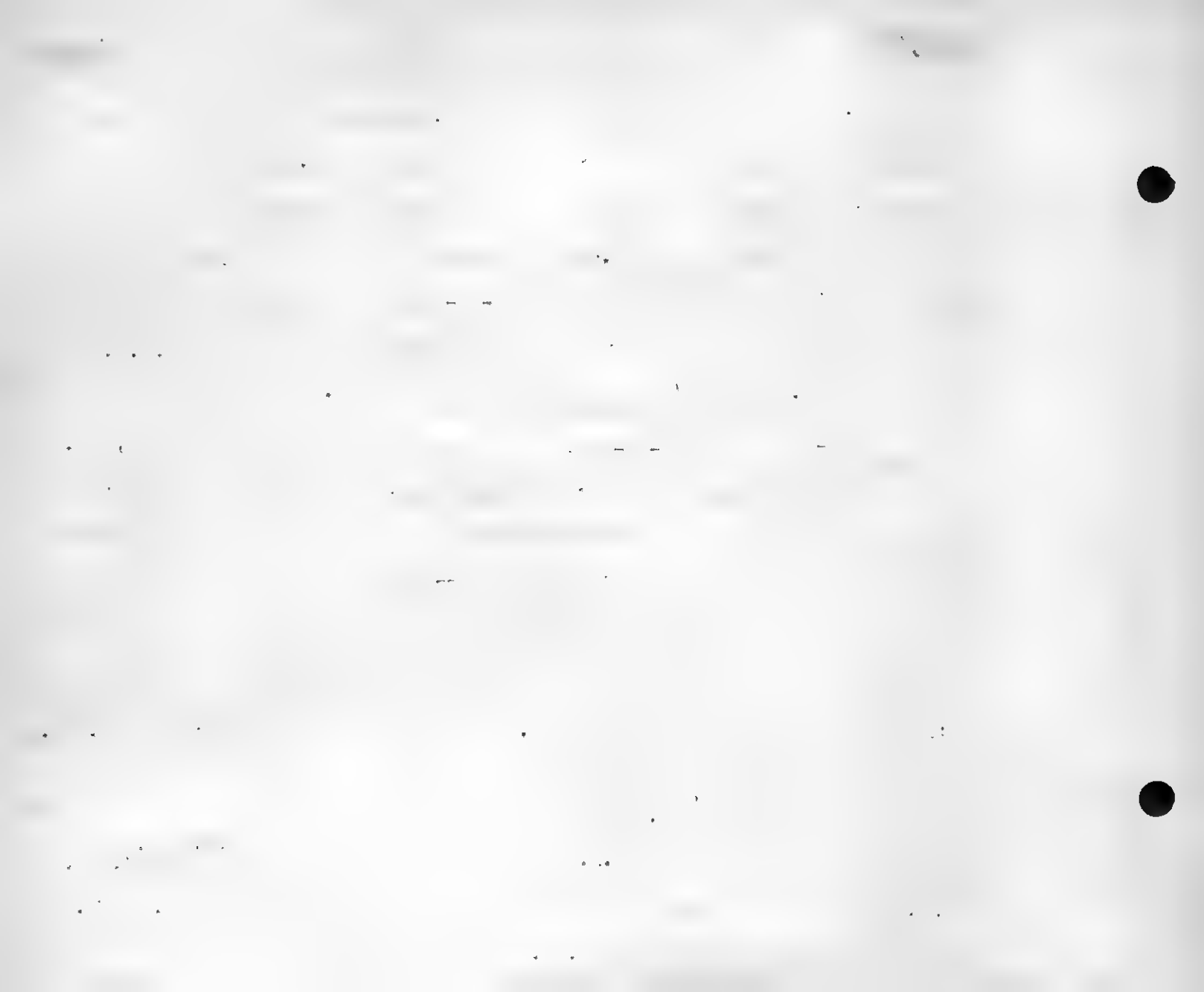
VR AISME (5)
SM 1/66

03079

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03066

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings		c. LENGTH OF STAY IN ID Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings Rt. 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital - DOA		d. STREET ADDRESS Cumberland, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ivan Middle Lynn Last Campbell		4. DATE OF DEATH Month March Day 11 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-1939	9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR: Months 26 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Worker		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Oliver . Campbell		14. MOTHER'S MAIDEN NAME Mary S. Cook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1957-1958		17. INFORMANT Oliver Campbell	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage DUE TO (b) Skull Fracture DUE TO (c) (Auto Accident--Driver)		INTERVAL BETWEEN ONSET AND DEATH Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of automobile which struck tree			
20c. TIME OF INJURY Month, Day, Year Hour 12:30 p.m. March 11 1966		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 220 2 Mile South Cresaptown, Alleg. Md.	
20f. (City or town) Allegany Co. Md.		20g. (County) Allegany Co.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED March 11, 1966	
ACTUAL SIGNATURE Benedict Skitarelic		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 13 Mar 1966		23c. NAME OF CEMETERY OR CREMATORY Waxler	
23d. LOCATION (City, town or county) Allegany Co. Md.		23e. (State) Md.			
24. FUNERAL DIRECTOR Allen M. Rotunck		ADDRESS KEYSER, W.VA.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 14 1966			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

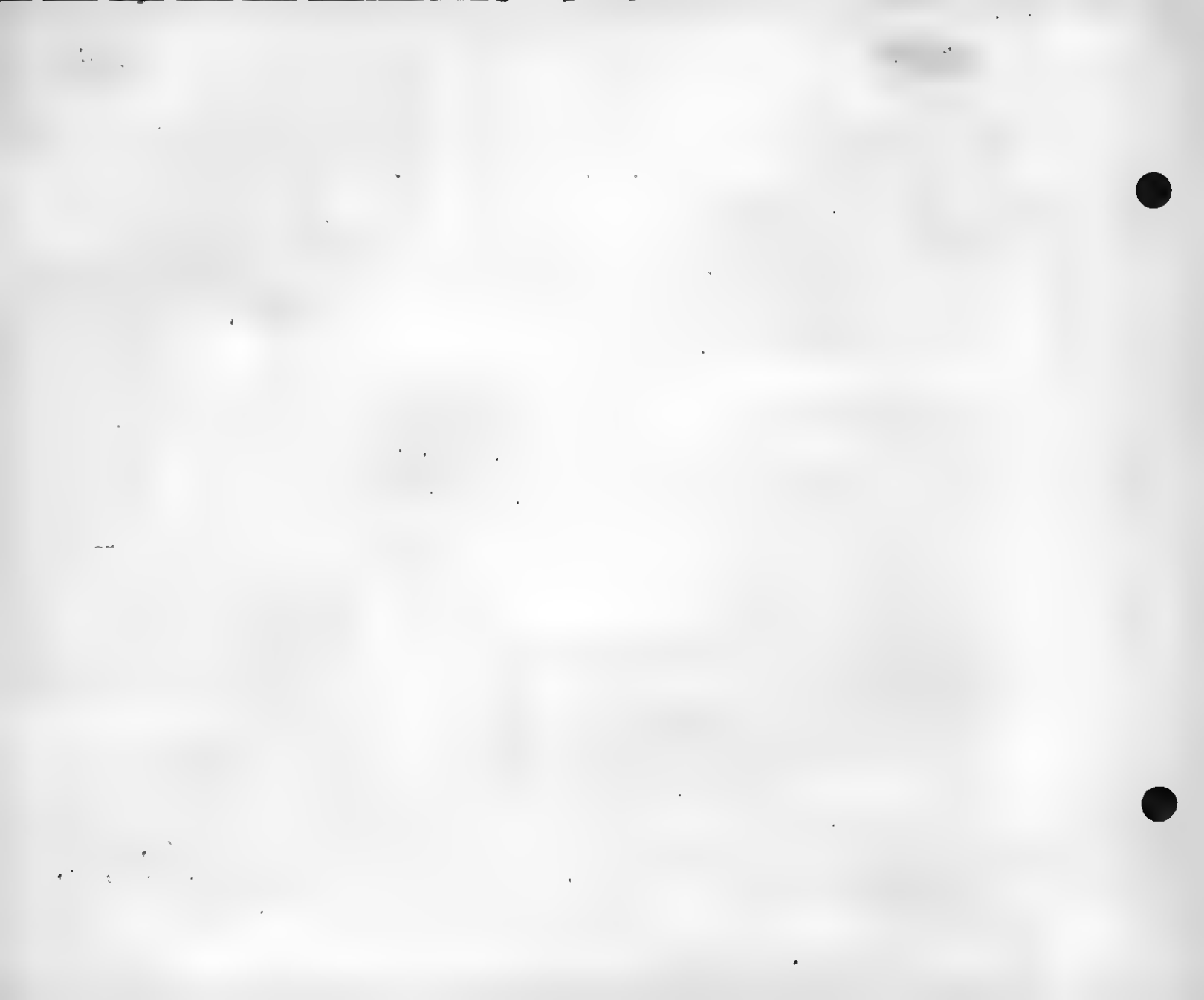
1
M
FOR STATE
HEALTH DEPT.

03080

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03067

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MT SAVAGE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS MAIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH E. CAMPBELL			4. DATE OF DEATH Month Day Year MARCH 25 1966				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 28th, 1903		9. AGE (in years last birthday) 62 YRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TICKET SELLER		10b. KIND OF BUSINESS OR INDUSTRY RACING COMMISSION		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MATTHEW CAMPBELL			14. MOTHER'S MAIDEN NAME SARAH CONROY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-4660		17. INFORMANT MRS. MARGARET G. CAMPBELL			Address MAIN STREET, MT. SAVAGE, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4-01 DUE TO (b) CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				22. DATE SIGNED March 25, 1966			
EXAMINER'S NAME (Type) R. BENEDICT SKITARELIC, M.D.				Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-23-66		23c. NAME OF CEMETERY OR CREMATORY ST. PATRICK'S CEMETERY		23d. LOCATION (City, town or county) (State) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR Joseph E. Durst, Sr.				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR MAR 30 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

03081

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03068

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 F Jane Frazier Village		d. STREET ADDRESS 5 F Jane Frazier Village	
3. NAME OF DECEASED (Type or print) First Arthur Middle Clelland Last Charlton		4. DATE OF DEATH Month March Day 19 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel	9. AGE (In years last birthday) yrs 68
11. BIRTHPLACE (State or foreign country) Moorefield, W. Va.		12. COUNTRY OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur A. Charlton		14. MOTHER'S MAIDEN NAME Mary M. Boswell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War I		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Beulah Corbett, Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) CORONARY SCLEROSIS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 23, 1966	23c. NAME OF CEMETERY OR CREMATORY Oliver Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAR 22 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

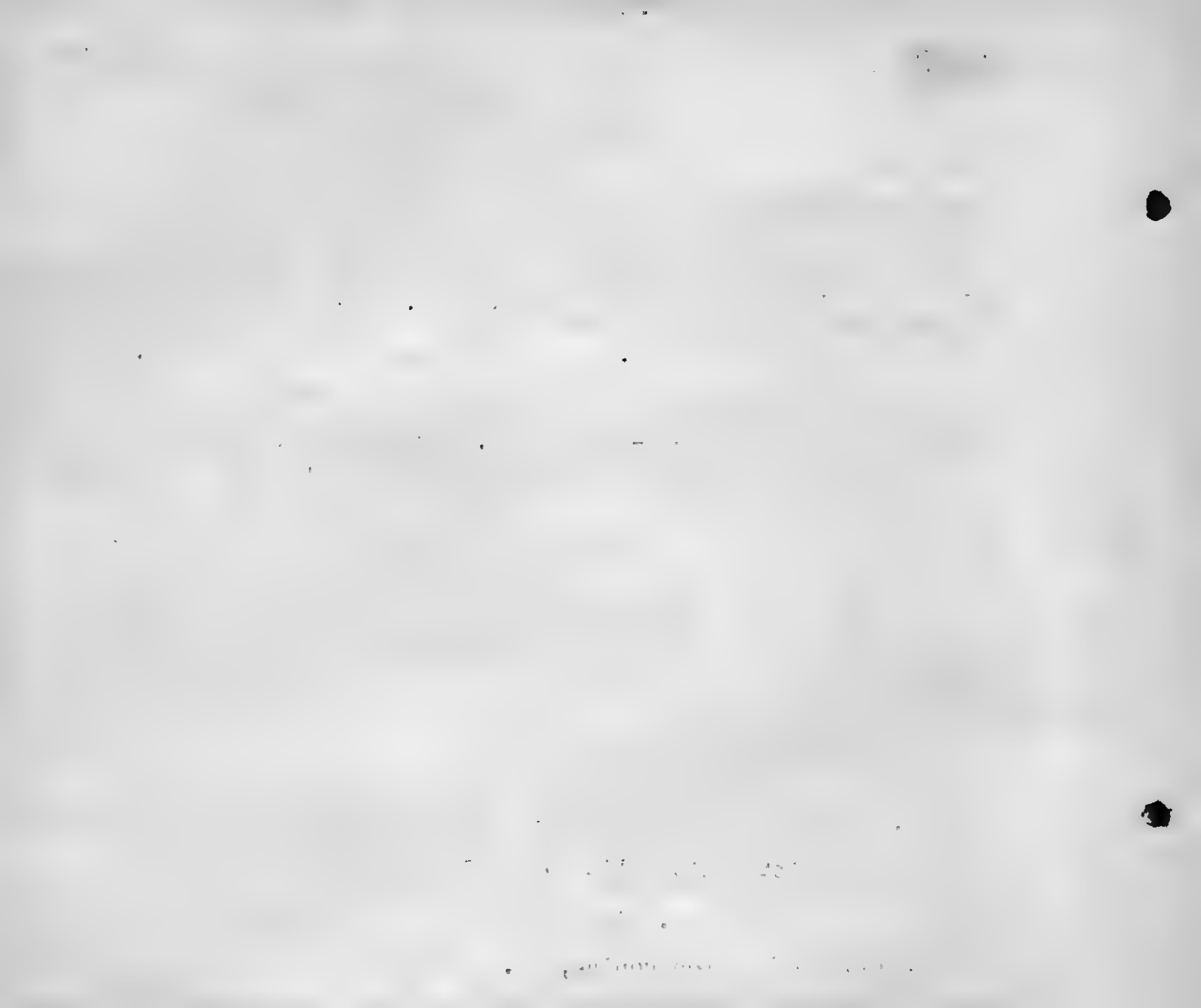
03069

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN lb 66 years c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Maryland	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital D.O.A.		d STREET ADDRESS 930 Glenwood St. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Robert Middle Smith Last Clegget		4 DATE OF DEATH March 31 1966	
5 SEX Male	6 COLOR OR RACE Colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH September 17, 1899
9 AGE (In years last birthday) 66 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Forman Garbage Collection Sanitation	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Allegany Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME William E. Clegget	
14 MOTHER'S MAIDEN NAME Ellen Clegget		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown	
16 SOCIAL SECURITY NO		17 INFORMANT Maude Clegget Address 930 Glenwood St.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4 10 11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF April 4, 1966	23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d LOCATION (City or Town) (County) (State) Cumberland Allegany Md.
24 FUNERAL DIRECTOR Louis Stein Inc Cumb. Md.		25a. REC'D BY REGISTRAR APR 5 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

03071

03084

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in 1b 18 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 959 National Hwy. LaVale	
3. NAME OF DECEASED (Type or print) First William Middle Edgar Last Crites		4. DATE OF DEATH Month March Day 22 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-1894
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION WORKER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (County & State, or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Crites		14. MOTHER'S MAIDEN NAME Rose May Crites	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 232 18 3664	
17. INFORMANT Patient's Chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular Thrombocytosis DUE TO (b) Myocardial Infarction DUE TO (c) Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH 3 wks. 20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-4 , 19 66 to 3-22 , 19 66 that (I) (we) last saw the deceased alive on 3-22 , 19 66 , and that death occurred at 1P M, from causes and on the date stated above.			
22a. SIGNATURE L. Michael Glick		22b. DATE SIGNED 3-24-66	
22c. PHYSICIAN'S NAME (Type) L. Michael Glick		22d. ADDRESS 126 N. Smallwood St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 25, 1966	23c. NAME OF CEMETERY OR CREMATORY ST. PETER & PAUL CEMETERY	23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR MAR 28 1966	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03085

CERTIFICATE OF DEATH

03072

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
c. LENGTH OF STAY IN lb 65 Yrs		d. STREET ADDRESS 233 Md. Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 233 Md. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Cross		4. DATE OF DEATH Month Mar. Day 24 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1880
9. AGE (in years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Lithuania	
13. FATHER'S NAME Thomas Vivado		14. MOTHER'S MAIDEN NAME not known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) 18		16. SOCIAL SECURITY NO	
17. INFORMANT Rose Cross-Westernport, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerosis DUE TO Arteriosclerosis (b) Arteriosclerosis (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1964 , to 3-24- , 1966, that (I) (the) last saw the deceased alive on 3-20 , 1966, and that death occurred at 3:00 PM from causes and on the date stated above.			
22a. SIGNATURE Robert W. Bess		22b. DATE SIGNED 3-25-66	
22c. PHYSICIAN'S NAME (Type) Robert W. Bess		22d. ADDRESS Piedmont, W.Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/28/66	23c. NAME OF CEMETERY OR CREMATORY St. Peters	23d. LOCATION (City or Town) (County) (State) Westernport Md
24. FUNERAL DIRECTOR Elizal		25a. REC'D BY REGISTRAR MAR 28 1966	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9 60

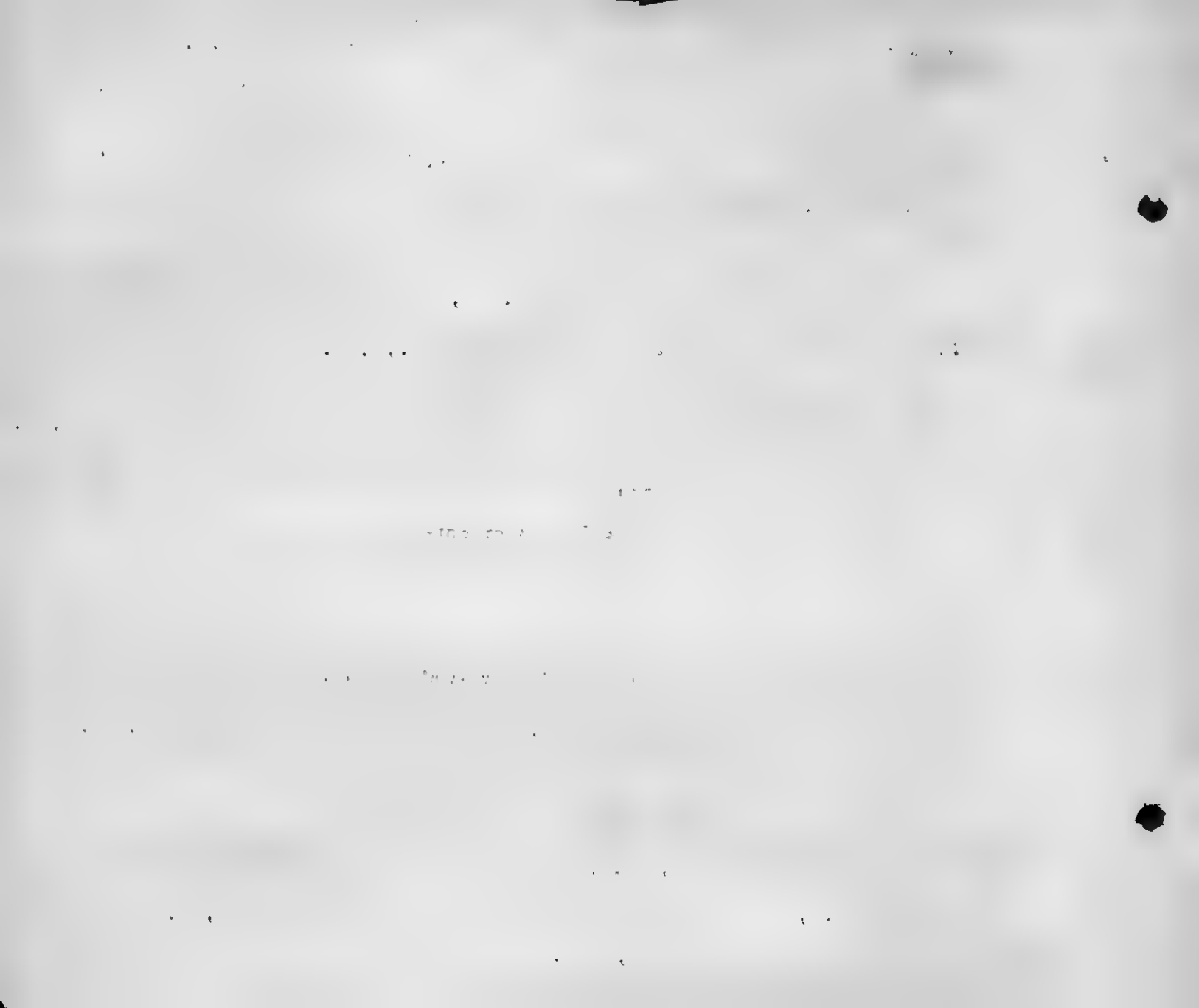
1M
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03086

03073

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Memorial Hospital		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cumberland, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 3 Rawlings, Maryland	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Edward Crossland		4. DATE OF DEATH March 5th 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1917
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinner		10b. KIND OF BUSINESS OR INDUSTRY Textile	
11. BIRTHPLACE (State or foreign country) Grant Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard Crossland		14. MOTHER'S MAIDEN NAME Lillie Flanagan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of serv. ce) No		16. SOCIAL SECURITY NO. 217 10 7744	
17. INFORMANT Elizabeth Jane Crossland		Address Rt #3, Rawlings, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) Crushed Skull (Automobile Accident-Driver) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Interval between onset and death Sudden		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Driver of Automobile involved in accident		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Driver of Automobile involved in accident	
20c. TIME OF INJURY Hour 10:15 p.m. Month, Day, Year March 5, 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 220--2 mile South, Rawlings, Alleg. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 9, 1966	
22c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery		22d. LOCATION (City, town, or country) (State) Rt #3, Rawlings, Md.	
23. FUNERAL DIRECTOR Aile M. Kotruck		24a. REC'D BY REGISTRAR MAR 7 1966	
24b. REGISTRAR'S SIGNATURE Charles Judge			



1 FOR STATE HEALTH DEPT. 03087 MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03074

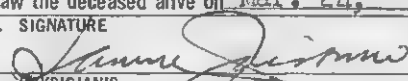


1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 26 BEALL'S LANE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG d. STREET ADDRESS 26 BEALL'S LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle GRANT Last DURST		4. DATE OF DEATH Month MARCH Day 5 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 13, 1894
9. AGE (in years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICE MANAGER	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICE MANAGER		10b. KIND OF BUSINESS OR INDUSTRY MORTON'S GARAGE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HUDSON DURST		14. MOTHER'S MAIDEN NAME HARRIETT PRESTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 414-05-1423	
17. INFORMANT JOHN C. DURST, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 4201 DUE TO (b) Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 3/5/66		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAR. 8 '66	
23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR MAR 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

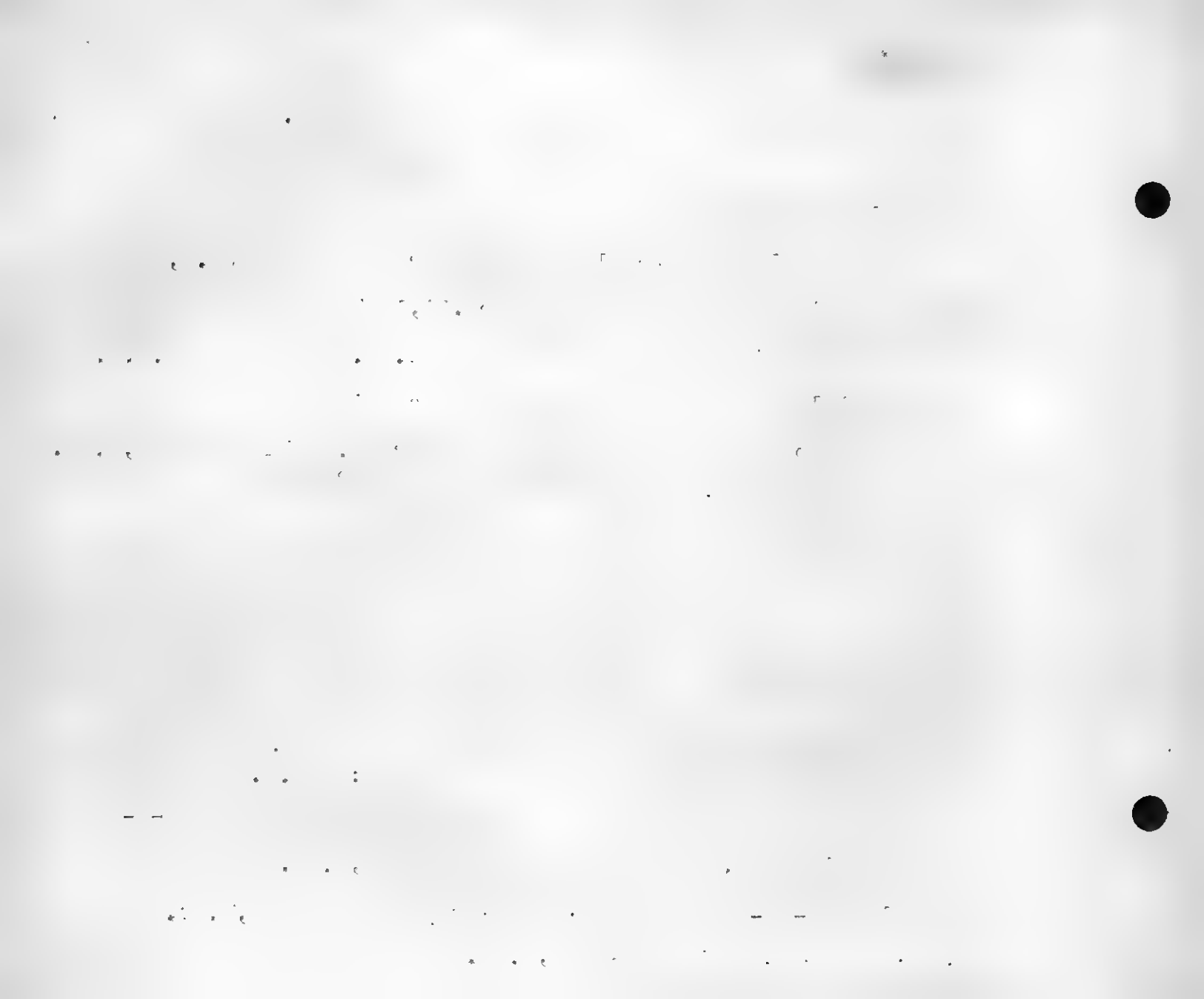
<div style="display: flex; justify-content: space-between;"> <div> 03088 <div style="border: 1px solid black; border-radius: 50%; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center; margin: 5px;">M</div> </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH <div style="display: flex; justify-content: space-between;"> <div> DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DR. JACOBSON </div> <div> CERTIFICATE OF DEATH </div> <div> 03075 </div> </div> </div> </div>										
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 12 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT,					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 421 WALNUT STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last LUTHER O. EVANS					4. DATE OF DEATH Month Day Year MARCH 25 19 66					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-8-1885		9. AGE (In years last birthday) 80 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY MINER		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DAVID EVANS					14. MOTHER'S MAIDEN NAME ARMEDA KESSEL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Acute Left Ventricular Failure IMMEDIATE CAUSE (a)									INTERVAL BETWEEN ONSET AND DEATH Sudden	
4301 DUE TO Aricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Coronary Arteriosclerosis (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Silicosis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 13, 1966 to March 25, 1966 , that (I) (we) last saw the deceased alive on Mar. 24, 1966 , and that death occurred at 3:10 AM , from the causes and on the date stated above.										
22a. SIGNATURE 					22b. DATE SIGNED Mar. 26, 1966		22c. PHYSICIAN'S NAME (Type) DR. SAMUEL M. JACOBSON			
22d. ADDRESS 50 PERSHING STREET, CUMBERLAND, MD.					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/28/66		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town or county) (State) Westernport Md.			
24. FUNERAL DIRECTOR 					ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE MAR 29 1966			
					25b. REGISTRAR'S SIGNATURE 					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
03089					03076				
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland. b. COUNTY Allegany				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dawson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dawson Barton			d. STREET ADDRESS Railroad St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Van Pelt Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Ethel Middle Brill Last Fazenbaker			4. DATE OF DEATH Month March Day 8 Year 1966						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 21, 1907		9. AGE (in years last birthday) 58 yrs. IF UNDER 1 YEAR: Months 10 Days 17 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Wife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Zepp, Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Brill					14. MOTHER'S MAIDEN NAME Rose Miller				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. No		17. INFORMANT Robert L. Brill			Address Keyser, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 6000 DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) Chronic pyelonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH (Brother) minutes ten years years				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from December, 1961 , to March 5, 1966 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Phillip G. Staggers</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3-8-66	
22c. PHYSICIAN'S NAME (Type) Phillip G. Staggers					22d. ADDRESS Keyser, W. Va.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-11-66		23c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery			23d. LOCATION (City, town or county) (State) Keyser, W. Va.		
24. FUNERAL DIRECTOR <i>Thomas Smith Jr.</i>					25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
MAR 10 1966									



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03090

03077

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>21 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>17 Decatur St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u> d. STREET ADDRESS <u>17 Decatur St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George A. Flynn</u>		4. DATE OF DEATH <u>Mar. 7 1966</u>		Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Feb. 19, 1909</u>		9. AGE (In years last birthday) <u>57 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agent</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		13. BIRTHPLACE (County & State, or foreign country) <u>Harrison, W. Va.</u>	
14. CITIZEN OF WHAT COUNTRY <u>USA</u>		15. FATHER'S NAME <u>Justin P. Flynn</u>		16. MOTHER'S MAIDEN NAME <u>Caroline (Gabbert) Flynn</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		18. SOCIAL SECURITY NO. <u>234-10-6249</u>		19. INFORMANT <u>Mrs. Beatrice Flynn</u>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Myocardial Infarction, recent</u> DUE TO (c) <u>Coronary Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 mo.</u> <u>7 yr.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>					
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>			
23. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. <u>None</u> <u>19</u>		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
26. (City or town) (County) (State)		27. (City or town) (County) (State)			
28. I certify that (I) (this hospital) attended the deceased from <u>July 17, 1959</u> to <u>March 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 7, 1966</u> and that death occurred at <u>5:30 AM</u> the causes and on the date stated above					
29. SIGNATURE <u>James P. Hallinan MD</u>		30. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		31. DATE SIGNED <u>2-8-66</u>	
32. PHYSICIAN'S NAME (Type) <u>Dr. James P. Hallinan</u>		33. ADDRESS <u>140 Bedford St., Cumberland, Md.</u>			
34. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		35. DATE THEREOF <u>Mar. 9, 1966</u>		36. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	
37. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>		38. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>			
39. ADDRESS <u>Cumberland, Md.</u>		40. REC'D BY REGISTRAR <u>Charles Judge</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03091

03078

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG d. STREET ADDRESS 76 W. MECHANIC ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First LULA Middle B. Last FOLK		4. DATE OF DEATH Month MARCH Day 11 Year 1966		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 4, 1884		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME THOMAS J. THOMAS								14. MOTHER'S MAIDEN NAME CLARA M. WADE											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT CHAS. E. FOLK, FROSTBURG, MD.				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior closure of the Cardiovascular Disease 4221 DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																INTERVAL BETWEEN ONSET AND DEATH 20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Huge Uterine Fibroid - Acute																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 6 MARCH, 1966 , to 11 MARCH, 1966 , that (I) (we) last saw the deceased alive on 11 MARCH 1966 , and that death occurred at 9AM , from the causes and on the date stated above.																			
22a. SIGNATURE Martin M. Rothstein												22b. DATE SIGNED 3/13/66							
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M. D.												22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF MAR. 14 '66				23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK				23d. LOCATION (City, town or county) (State) FROSTBURG, MD.							
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.												25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE MAR 15 1966																			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03092

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03079

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 25 years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Denzil Middle H. Last Friend				4. DATE OF DEATH Month March Day 1 Year 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1914	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1		11. IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Swanton, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry W. Friend				14. MOTHER'S MAIDEN NAME Maggie R. xrode			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Hazel P. Leslie, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, BILATERAL 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				22. DATE SIGNED MARCH 1, 1966			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 4, 1966		23c. NAME OF CEMETERY OR CREMATORY United Brethren Cemetery		23d. LOCATION (City, town or county) (State) Swanton, Maryland	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR MAR 4 1966			
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03093					03080				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Allegany			a. STATE		Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Lonaconing			b. COUNTY		Allegany		
c. LENGTH OF STAY IN 1b		2 months			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Kyle Nursing Home			d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM?					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
Catherine Nickle Geiger					March 9, 1966 19				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 30, 1934		61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife				Allegany Co., Maryland		USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Harry Nickle					Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		None		Oklen H. Geiger		Corrigansville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic C V disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic gangrene left leg								INTERVAL BETWEEN ONSET AND DEATH 2 days years	
19. WAS AUTOPSY PERFORMED?								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		19					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 3-9, 1966, that (I) (we) last saw the deceased alive on 3-8, 1966, and that death occurred at 5P M, from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
		H. Miles Jr.		3-11-66		L.R. MILES, JR., M.D.		LONACONING MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
Burial		Mar. 12, 1966		Rest Land Memorial Park		Cash Valley Rd. Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harvey H. Zeigler		Hyndman, Pa.		MAR 16 1966		J. Charles Judge			

03094

Item 3 Film 3375 8-11-66 rh

CERTIFICATE OF DEATH

03081

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport rural		c. LENGTH OF STAY IN 1b 40 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Lewis Garland Garland Lewis Grove		4. DATE OF DEATH Mar. 11 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1897
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months 68 Days 19 Hours 66 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11c. BIRTHPLACE (County & State, or foreign country) Garrett-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James L Grove		14. MOTHER'S MAIDEN NAME Lavina Fazenbaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 217-10-7964	
17. INFORMANT Mrs. Mary Grove		Address Westernport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Disease 4201 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 9, 1966 to Mar. 11, 1966 , that (I) (we) last saw the deceased alive on March 9, 1966 , and that death occurred at 8:28 A.M. from causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson		22b. DATE SIGNED Mar. 11, 1966	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson		22d. ADDRESS Piedmont, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/14/66	23c. NAME OF CEMETERY OR CREMATORY Philos	23d. LOCATION (City or Town) (County) (State) Westernport Md.
24. FUNERAL DIRECTOR E. J. B...		25a. REC'D BY REGISTRAR MAR 15 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03095 CERTIFICATE OF DEATH 03082

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 8 HRS 15 MIN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 10 EAST CLEMENT ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MITCHELL ROY HANSON		4. DATE OF DEATH Month Day Year MARCH 22 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 21, 1911
9. AGE (In years last birthday) 54		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Operator		10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.	
11. BIRTHPLACE (County & State, or foreign country) Monticell, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME XXXXXXXXXX		14. MOTHER'S MAIDEN NAME XXXXXXXXXXXXXXXXXXXX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 220-09-2327	
17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lateral Sclerosis of spine Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Massive Cerebral Hemorrhage DUE TO (c) Acute		INTERVAL BETWEEN ONSET AND DEATH June 1965	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 15, 66 9:25 to P.M. 3/22/19 66 that (I) (we) last saw the deceased alive on Mar. 22 19 66 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED 3/23/66	
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE. CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-25-1966	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAR 28 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME (5)
5M 1/65

03096

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03083

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN 1D D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE 1, FROSTBURG d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle S. Last HARVEY		4. DATE OF DEATH Month MARCH Day 23 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 6, 1892
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT HARVEY		14. MOTHER'S MAIDEN NAME MARY GIBSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 236-34-4639	
17. INFORMANT MRS. MAGGIE HARVEY, FROSTBURG, MD.		Address BOX 131, RT. 1,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		22. DATE SIGNED 3/23/66	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.		Address (Street, city, town, or county) RD 9, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-25-66	23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK	23d. LOCATION (City, town or county) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR MAR 28 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03084

1. PLACE OF DEATH

a. COUNTY

Allegheny

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Memorial Hosp. DOA

3. NAME OF DECEASED

(Type or print)

Julius

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED

8. DATE OF BIRTH

Nov. 7, 1889

9. AGE (In years last birthday)

76

10. IF UNDER 1 YEAR

Months Days Hours Min.

11. IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Car Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Sports' Garage

11. BIRTHPLACE (County & State, or foreign country)

Cumberland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frederick

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Mrs Julius Host

18. ADDRESS

Cumberland Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

*Coronary Thrombosis
Arterio Scl. C.V.D.*

INTERVAL BETWEEN ONSET AND DEATH

1 hr -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. *19*

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED While at work Not While at work ☐ ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

(County)

(State)

Cumby, Allegheny Md

21. I certify that (I) (this hospital) attended the deceased from *7/27/66*, 19*66*, to *3/25/66*, 19*66*, that (I) (we) last saw the deceased alive on *2/10/66*, 19*66*, and that death occurred at *10A* M, from the causes and on the date stated above.

22a. SIGNATURE

R. Williams
Red Williams

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

3/25/66

23a. BURIAL, CREMATION, OR OTHER DISPOSITION

Buried

23b. DATE THEREOF

3/26/66

23c. NAME OF CEMETERY OR CREMATORY

St. Lukes Cem.

23d. LOCATION (City, town or county)

Cumberland Md.

23e. (State)

24. FUNERAL DIRECTOR'S SIGNATURE

Louis Stein Inc.

ADDRESS

Cumby Md.

25a. REC'D BY REGISTRAR

MAR 28 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03098

03085

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN b <u>16 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sylvan Retreat</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>621 N. Mechanic Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Helker</u> Last <u>Helker</u> 4. DATE OF DEATH <u>March 23</u> 19 <u>66</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 2, 1885</u> 9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Construction Worker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Allegany County Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Helker</u> 14. MOTHER'S MAIDEN NAME <u>Mary Ahouse</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>214-05-9588</u> 17. INFORMANT <u>John L. Helker</u> Address <u>621 N. Mechanic St Cumberland, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertension, etc., degenerative</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Brain aneurysm left foot, due to circulatory changes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 5, 1964</u> to <u>March 23, 1966</u> that (I) (we) last saw the deceased alive on <u>March 23, 1966</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above 22a. SIGNATURE <u>L. B. Mathews</u> M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>L. B. Mathews, M.D.</u> 22d. ADDRESS <u>49 Greene St., Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/26/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u> 23d. LOCATION (City, town or county) (State) <u>Cumberland Alleg Co Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u> ADDRESS <u>Cumberland Maryland 21502</u> 25. REC'D BY REGISTRAR <u>MAR 28 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03099 04607											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					
c. LENGTH OF STAY IN 1b <u>35 years</u>						d. STREET ADDRESS <u>34 Browning Street</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>34 Browning Street</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First <u>Edgar</u> Middle <u>Clayton</u> Last <u>Herring</u>			4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 4, 1889</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mt. Savage, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John C. Herring</u>						14. MOTHER'S MAIDEN NAME <u>Mary C. Hergot</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Mrs. Wm. Cassell, Cumberland, Md. - Daughter</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>525X</u> DUE TO <u>Ischemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Pulmonary Embolus</u> DUE TO <u>2 hrs</u> (c) <u>2 yrs</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1965</u> to <u>Mar 31, 1966</u> , that (I) (we) last saw the deceased alive on <u>Mar 3, 1966</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Clay E. Durrett</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/3/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Clay E. Durrett, M.D.</u>						22d. ADDRESS <u>236 Virginia Ave. Cumberland, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>April 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. George Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Mt. Savage, Md.</u>			
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VM A15 (4)
15M 9/59

1-10
M
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03100

03086

1. PLACE OF DEATH a. COUNTY <u>117</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>117</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>5 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Local Hospital</u>		d. STREET ADDRESS <u>Ellerlie</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Curtis Leroy Hickie</u>		4. DATE OF DEATH Month Day Year <u>March 27, 1966</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1920</u>
9. AGE (In years last birthday) <u>45</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Advertising</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George D. Hickie</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Burley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-3519</u>	
17. INFORMANT (If yes, give name and address) <u>Mrs. C. D. Hickie, 117 E. 1st St., Baltimore, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anisotropic Lateral Sclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-27</u> <u>1966</u> to <u>3-27</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>3-14</u> <u>1966</u> , and that death occurred at <u>2:25</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>William P. James</u>		22b. DATE SIGNED <u>3/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William P. James, M.D.</u>		22d. ADDRESS <u>441 N. Centre St., Cumberland, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 30, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>L. J. Barger Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Buffalo Mills, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler, Jr., Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

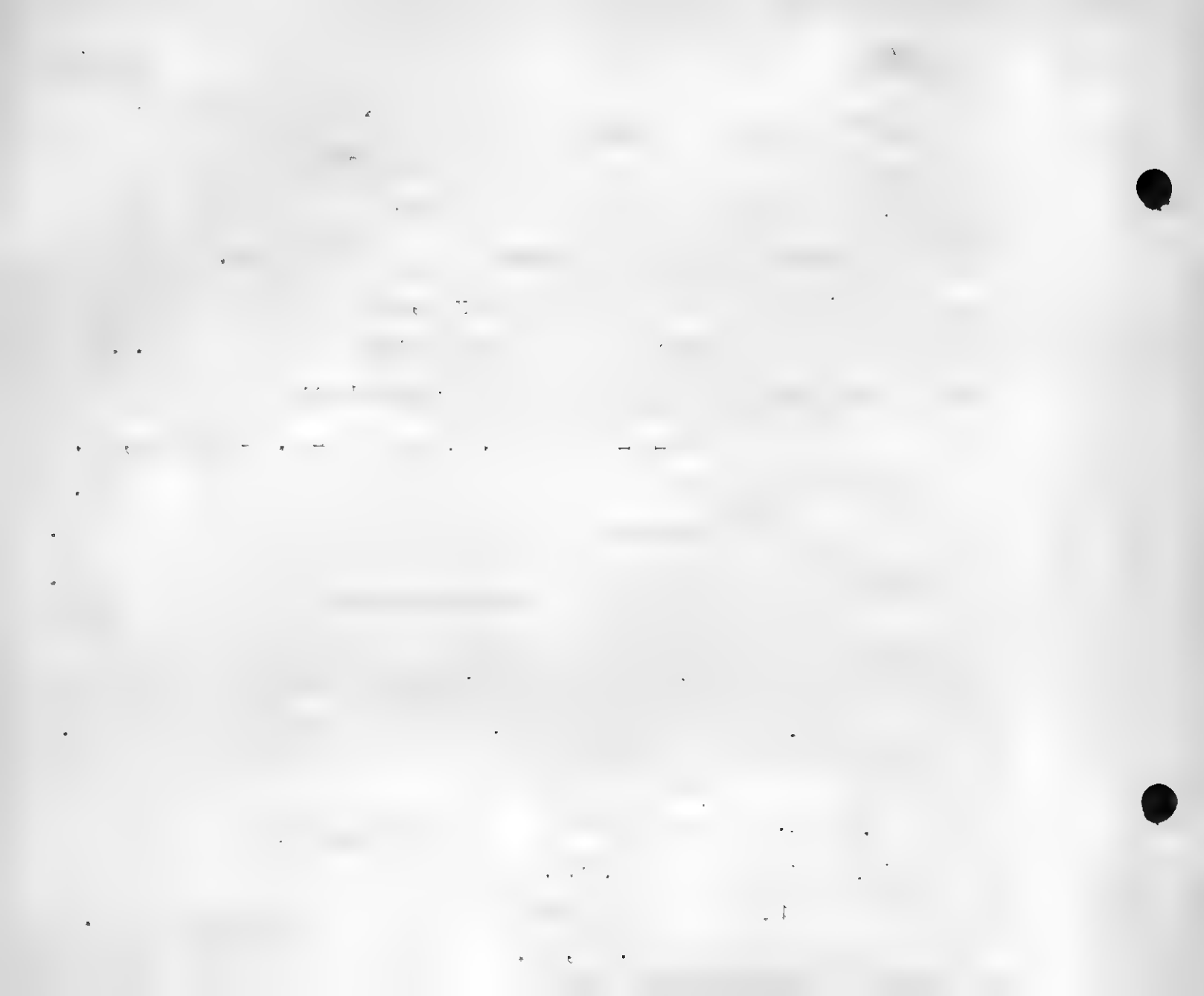
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03101

03087

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHIMBERLAND				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Frontburg			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Robert Howard				4. DATE OF DEATH Month Day Year Mar. 15 1966			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1906	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) West Virginia		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James Garland Howard				
14. MOTHER'S MAIDEN NAME Martha O'Neil			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				
16. SOCIAL SECURITY NO. 236-03-4262			17. INFORMANT Address Mrs. Doris Howard-Rd. 1-Frostburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 1559 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hemothorax DUE TO (c) Fractured Ribs						INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of Vehicle involved in accident					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5:05 p.m. 3/15/66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 36		20f. (City or town) (County) (State) Gilmore Allegany Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarellic			22. DATE SIGNED 3/15/66				
EXAMINER'S NAME (Type) DR. BENEDICT SKITARELLIC, M.D.			Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/66		23c. NAME OF CEMETERY OR CREMATORY Bloomington		23d. LOCATION (City, town or county) (State) Bloomington Md.	
24. FUNERAL DIRECTOR Westernport, Md.			25a. REC'D BY REGISTRAR MAR 21 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



CERTIFICATE OF DEATH

03102

04614

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN lb 5 HOURS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS' HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D. #2, BOX 581, FROSTBURG d. STREET ADDRESS BIG SAVAGE MOUNTAIN e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY BOY Middle IMES Last IMES 4. DATE OF DEATH Month MARCH Day 25 Year 1966		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH MARCH 25, 1966 9. AGE (In years last birthday) 5 IF UNDER 1 YEAR Months 5 IF UNDER 24 HRS. Hours 5 Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.A. 10b. KIND OF BUSINESS OR INDUSTRY N.A. 11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND 12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME EUGENE CUTTER 14. MOTHER'S MAIDEN NAME SALLY ANN IMES (UNMARRIED) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) N.A. 16. SOCIAL SECURITY NO. N.A. 17. INFORMANT MRS. MABEL CUTTER, R.F.D. #2, BOX 581 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - due to Premature Labor DUE TO (b) 5 hrs. Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. } DUE TO (c) NONE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) NONE	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE 20c. TIME OF INJURY Month, Day, Year 3/25, 1966 Hour a.m. ✓ p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓ 20f. (City or town) 3/25, 1966 (County) 3/25, 1966 (State) 1966	
21. I certify that (I) (this hospital) attended the deceased from 3/25, 1966 to 3/25, 1966 that (I) (we) last saw the deceased alive on 3/25, 1966 and that death occurred at 8 P.M. from the causes and on the date stated above.		22a. SIGNATURE Martin M. Rothstein, M.D. 22b. DATE SIGNED 4/12/66 22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D. 22d. ADDRESS 48 BROADWAY, FROSTBURG, MARYLAND 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF MAR. 26, 1966 23c. NAME OF CEMETERY OR CREMATORY MC KENZIE CEMETERY 23d. LOCATION (City, town or county) GARRETT COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Harley M. Myers 25. REC'D BY REGISTRAR APR 19 1966 25b. REGISTRAR'S SIGNATURE Charles Judge HAFER FUNERAL HOME, 60 W. MAIN ST., FROSTBURG, MD.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

03103

03088

1. PLACE OF DEATH

a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

FROSTBURG

c. LENGTH OF STAY IN

1 DAY

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MINERS' HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

MARYLAND

b. COUNTY

ALLEGANY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FROSTBURG

d. STREET ADDRESS

79 HILL STREET

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF

(Type or print)

First

ANNA

Middle

M.

Last

IRWIN

4. DATE OF DEATH

Month

Day

Year

MARCH

25

19 66

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED ☐

8. DATE OF BIRTH

MARCH 23, 1891

9. AGE (In years last birthday)

75 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (County & State, or foreign country)

FRIENDSVILLE, MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN MYERS

14. MOTHER'S MAIDEN NAME

MONTERA BARNHOUSE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give year or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Address FROSTBURG, D.

MRS. ANDREW LASLO, 85 HILL STREET

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Cardiac Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

Auricular Fibrillation

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 days

24 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Pos. Carcinoma of head of Pancreas

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m.
p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from March 20, 1966 to March 25, 1966, that (I) last saw the deceased alive on March 25, 1966, and that death occurred at 8 A.M. from the causes and on the date stated above.

22a. SIGNATURE

John B. Davis, M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS. ☐

22b. DATE SIGNED

3/28/66

22c. PHYSICIAN'S NAME (Type)

JOHN B. DAVIS, M.D.

22d. ADDRESS

2 BROADWAY, FROSTBURG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

MAR. 28, 1966

23c. NAME OF CEMETERY OR CREMATORY

FROSTBURG MEM. PARK

23d. LOCATION (City, town or county)

FROSTBURG

(State)

MD.

24. FUNERAL DIRECTOR'S SIGNATURE

HAFFER FUNERAL HOME, 60 W. MAIN ST.

ADDRESS

25a. REC'D BY REGISTRAR

APR 1 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

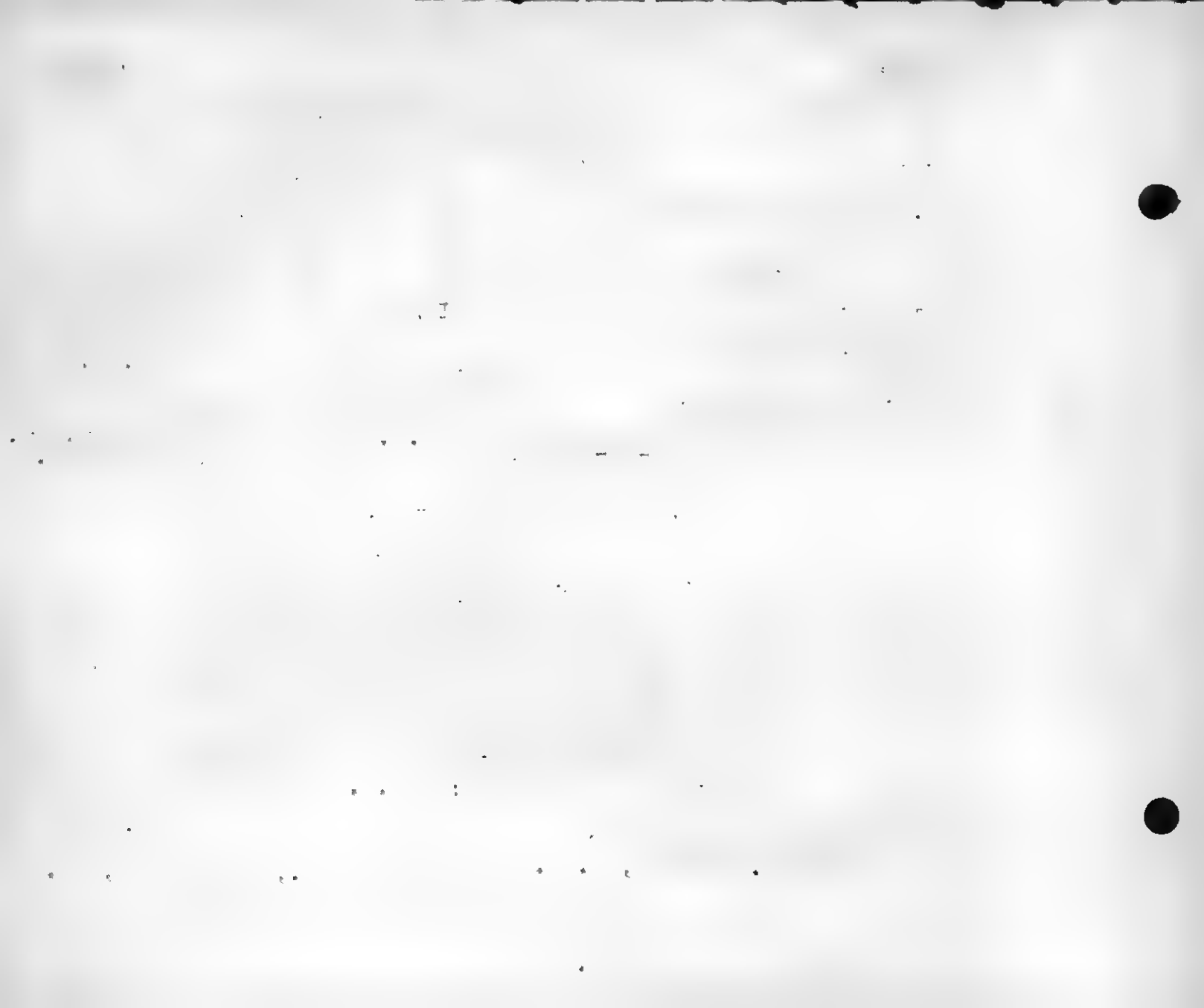
1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03104

03089

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9/10/60			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary				d. STREET ADDRESS 460 Footer Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Margaret Middle Adele Last Johnson				4. DATE OF DEATH Month March Day 13 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12/13/1889	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U. S. A			
13. FATHER'S NAME William Henry Gladhill				14. MOTHER'S MAIDEN NAME Susan Rebecca Sock			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 217-I4-4549			
17. INFORMANT P.O. Box 599 Cumberland, Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis obs. degenerating to acute decompensation to Arteriosclerosis DUE TO (b) Bilateral cataracts DUE TO (c) Malignant lymphoma to secondary metastasis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/10/60 , 19 3/13/66 , to 3/12/66 , 19 3/12/66 , that (II) (we) last saw the deceased alive on 3/12/66 , and that he died at 8:25 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Lee B. Mathews				22b. DATE SIGNED 3/14/66			
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 16, 1966		23c. NAME OF CEMETERY OR CREMATORY GREEN HILL CEMETERY		23d. LOCATION (City, town or county) (State) WAYNESBORO, PA.	
24. FUNERAL DIRECTOR POE FUNERAL HOME				25a. REC'D BY REGISTRAR 16 MAR 1966			
25b. REGISTRAR'S SIGNATURE J. Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03105					03090						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 622 SHRIVER AVE.				
a. STATE MARYLAND		b. COUNTY ALLEGANY			b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
c. LENGTH OF STAY IN 1b 9 DAYS		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL									
3. NAME OF DECEASED (Type or print)		First WALLACE			Middle -- JOHNSON			Last			
4. DATE OF DEATH		Month MARCH			Day 27			Year 19 66			
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/02		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchandising Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Henry H. JOHNSON					14. MOTHER'S MAIDEN NAME Frances Johnson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-05-4202		17. INFORMANT RM MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lungs 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH First diagnosed Aug. '65	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 8-21-1965 to 3-27-1966 , that (I) last saw the deceased alive on 3-27-1966 , and that death occurred at 10:57 AM from the causes and on the date stated above.											
22a. SIGNATURE W.F. Williams M.D.										22b. DATE SIGNED 3-28-66	
22c. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS										22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/30/66		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION (City, town or county) (State) Cumberland, Maryland				
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland					25a. REC'D BY REGISTRAR MAR 30 1966		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]				

FOR STATE HEALTH DEPT.

M 03106

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03091

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

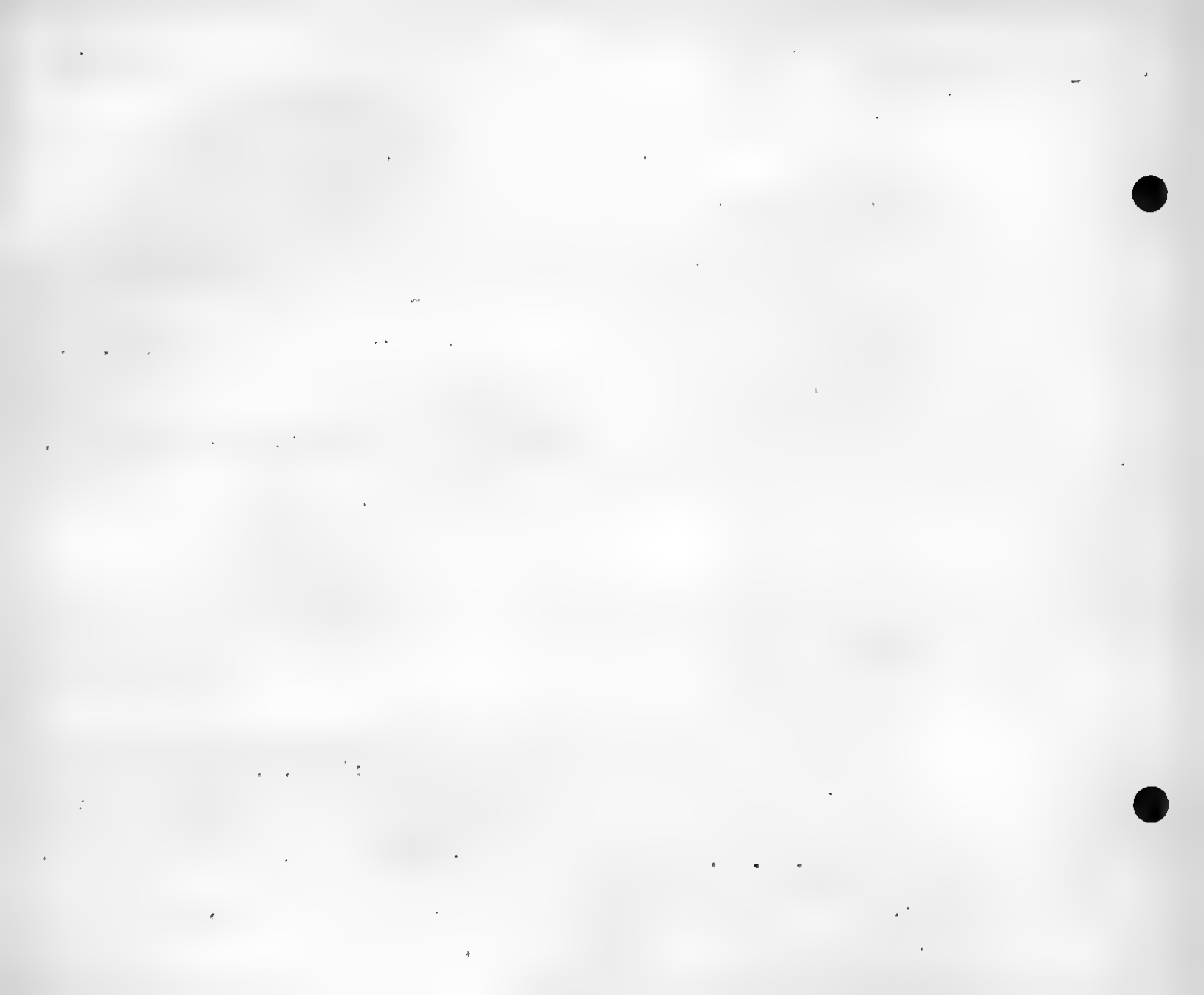
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 20 years		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3 NAME OF DECEASED (Type or print) First John Middle Leroy Last Keiley		4 DATE OF DEATH Month March Day 2 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 16, 1945
9 AGE (In years lost birthday) yrs 20		10 IF UNDER 1 YEAR Months Days Hours Min 01 - 01 - 01	
10a USUAL OCC. PAT. ON (Give kind of work done during most of working life, even if retired) Active Duty-U. S. Marine Corp. Reserve		10b KIND OF BUSINESS OR IND. STRY Cumberland, Md.	
11 BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James E. Keiley		14 MOTHER'S MAIDEN NAME Myrtle Lechlitter	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) yes U.S.M. Reserve		16 SOCIAL SECURITY NO Mr. James E. Keiley, Cumberland, Md.	
17 INFORMANT Mr. James E. Keiley, Cumberland, Md.		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SHOCK, IRREVERSIBLE 976 X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) ABDOMINAL HEMORRHAGE DUE TO (c) GUNSHOT OF ABDOMEN (SELF INFLICTED)			INTERVAL BETWEEN ONSET AND DEATH 5 1/2 Hours 5 1/2 Hours 5 1/2 Hours
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Unetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED March 2, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Md.		23a LOCATION (City or Town) (County) (State)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF March 5, 1966	23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a REC'D BY REGISTRAR MAR 4 1966	
25b REGISTRAR'S SIGNATURE Charles Judge		25c REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

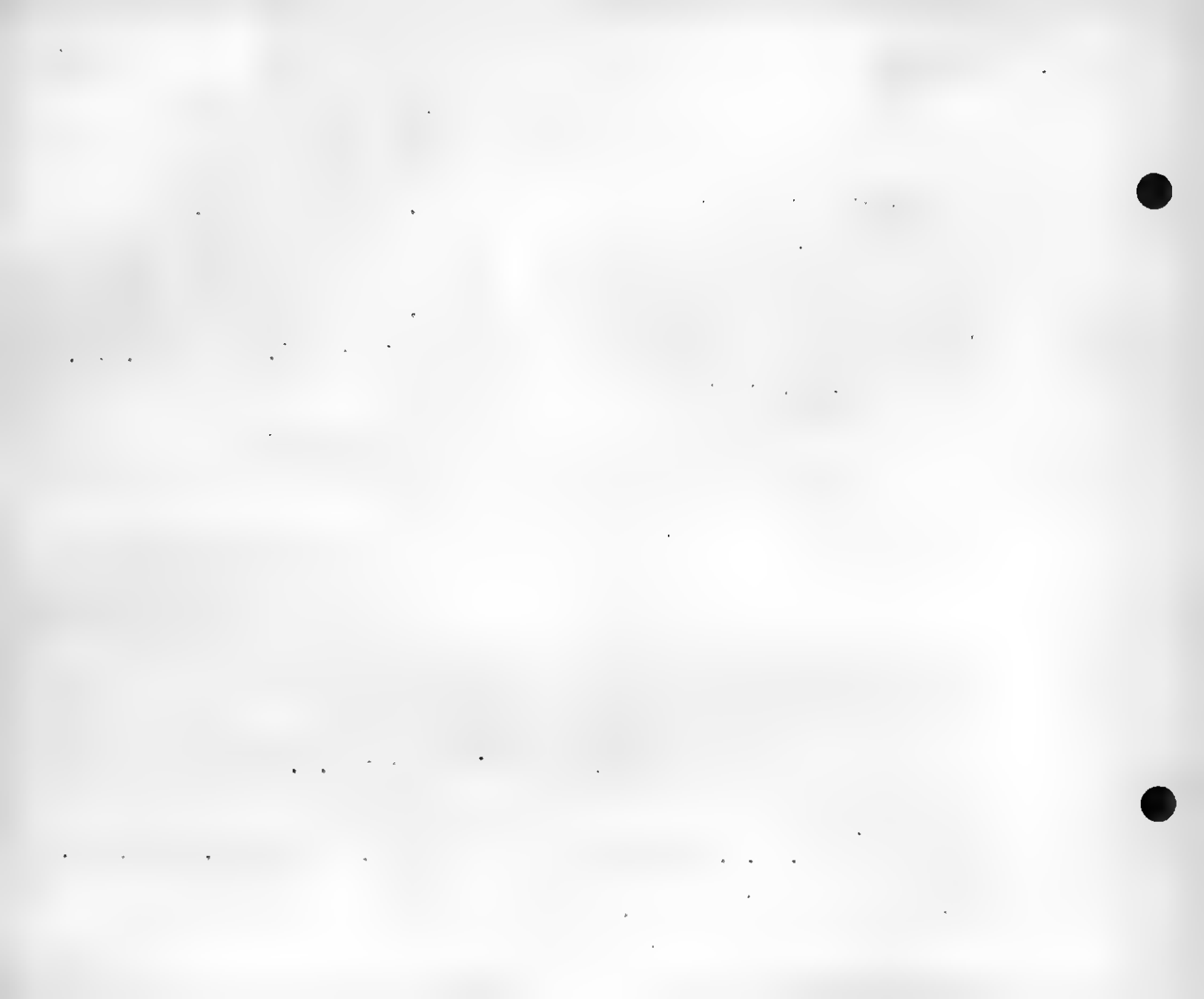
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
03107		03092							
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 18 HOURS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) NIKEP d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C. Last KIDDY			4. DATE OF DEATH Month MARCH Day 8 Year 19 66		5. SEX MALE			6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-12-1911		9. AGE (in years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) LONA CONING, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME ROBERT KIDDY			14. MOTHER'S MAIDEN NAME LOTTIE LEE						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 220-03-7059		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 260X DUE TO (b) Heart - failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3/7, 19 66 to 3/8, 19 66 , that (I) (we) last saw the deceased alive on 3/8 19 66 , and that death occurred at 9:15 AM , from the causes and on the date stated above.									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE [Signature] M.D.			ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/10/66
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN			22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/11/66		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City, town or county) (State) Moscow, Md.			
24. FUNERAL DIRECTOR George Eichhorn			ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR MAR 14 1966		25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03108											
03093											
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 103 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND f. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS RT.#4, OLDTOWN RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First ANNA Middle FRANCES Last KIPE					4. DATE OF DEATH Month MARCH Day 7 Year 1966						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 24, 1928		9. AGE (In years last birthday) 37 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Appliance Store		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME ALBERT THEODORE RICE					14. MOTHER'S MAIDEN NAME ROSE MARY MAFFLEY						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced Ca of ex 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) widespread metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 18 mo	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from NOV. 24, 1965 to MARCH 7, 1966 , that (I) (we) last saw the deceased alive on MARCH 7, 1966 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE A. J. Mirkin					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) DR. A.J. MIRKIN				
22d. ADDRESS 115 S. CENTRE ST. CUMB. MD.					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 10, 1966		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR MAR 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03109

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03094

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 26 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 4, Oldtown Road		d. STREET ADDRESS RFD 4, Oldtown Road	
3. NAME OF DECEASED (Type or print) First Wesley Middle James Last Kipe, Sr.		4. DATE OF DEATH Month March Day 20 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1891-75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	9. AGE (in years last birthday) 75 yrs
11. BIRTHPLACE (State or foreign country) Knoxville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Kipe		14. MOTHER'S M maiden name Etta Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War K		16. SOCIAL SECURITY NO. Raymond Kipe, Cumberland, Md.-Son	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1621 DUE TO HYDROTHORAX, PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) BRONCHOGENIC CARCINOMA (c)			INTERVAL BETWEEN ONSET AND DEATH HOURS MONTHS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 20, 1966 Address (Street, city, town or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 23, 1966	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAR 22 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

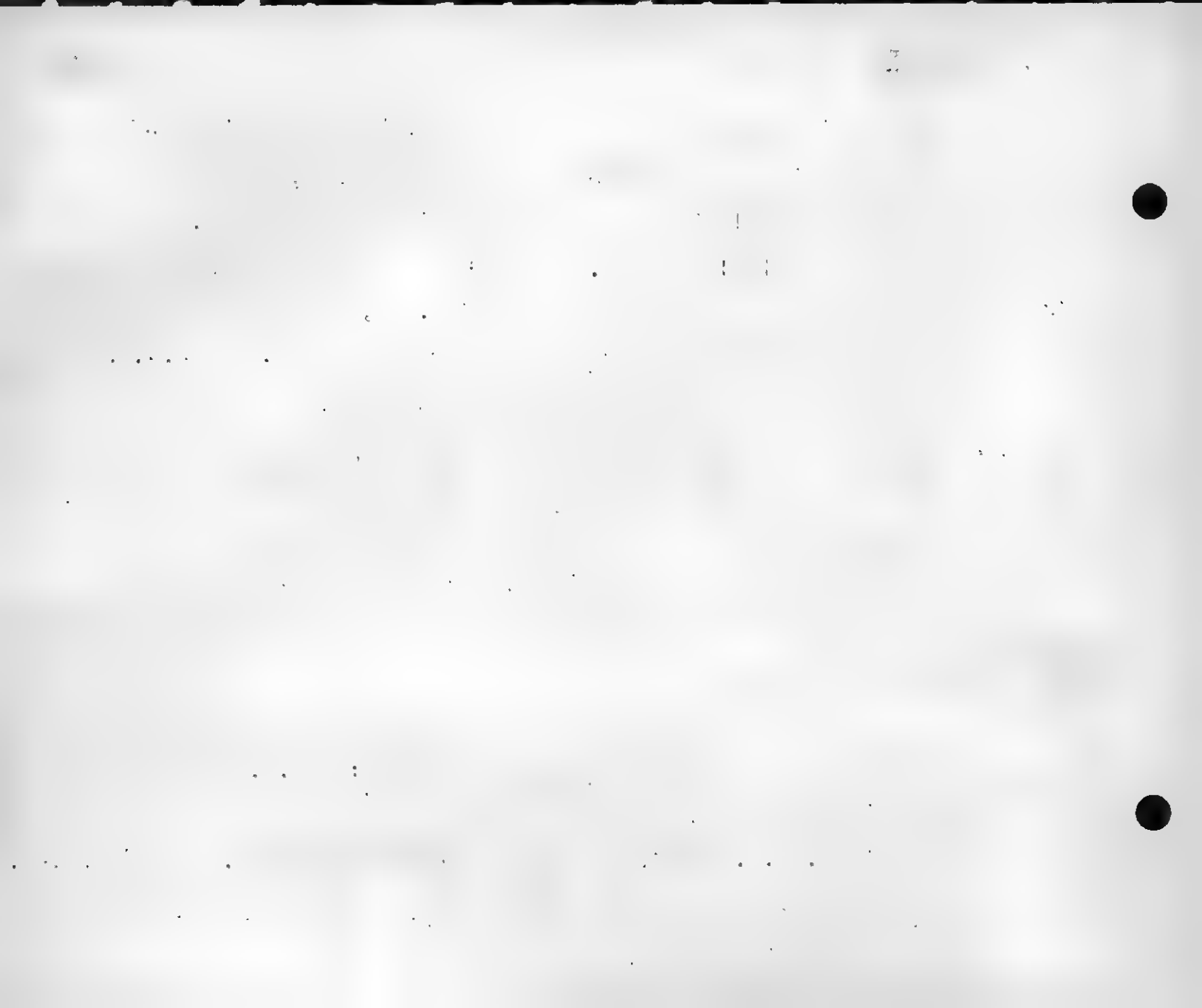
52

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03110					CERTIFICATE OF DEATH			03095	
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 14 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL					d. STREET ADDRESS 800 COLUMBIA AVE.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HATTIE Middle ELIZABETH Last KIRK					4. DATE OF DEATH Month 3 Day 24 Year 1966				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/19/92		9. AGE (In yrs lost birthday) 73 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Cumberland MARYLAND			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Joseph Smith					14. MOTHER'S MAIDEN NAME Rose Hall				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.			16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Maurice Kirk			Address 800 Columbia Ave Cumb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 1 day 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3 - 23 , 19 66 , to 3 - 24 , 19 66 , that (I) (we) last saw the deceased alive on 3 - 23 , 19 66 , and that death occurred at 4 A . M., from causes and on the date stated above.									
22a. SIGNATURE Dr. R. Ballin					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-24-66		
22c. PHYSICIAN'S NAME (Type) DR. R. BALLIN					22d. ADDRESS 62 Greene St. Cumberland, Md 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3/26/66		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR H. Wayne George					ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR MAR 28 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
031111 CERTIFICATE OF DEATH 03096									
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD d. STREET ADDRESS 615 PATTERSON AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First WILLIAM Middle G. Last KOLB			4. DATE OF DEATH Month MARCH Day 9 Year 1966						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 28, 1883		9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR: Months 2 Days 8 Hours 2 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tool Operator Tool Co				10b. KIND OF BUSINESS OR INDUSTRY Tool Co		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE KOLB					14. MOTHER'S MAIDEN NAME EMMA CASTLE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. —		17. INFORMANT MEMORIAL HOSPITAL			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526X Drown in canal DUE TO (b) 1/2 hour DUE TO (c) Anterior wall of left ventricle of heart PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 10 yrs 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1750 10:15 P.M. 3/7, 1966 , that (I) (we) last saw the deceased alive on 3/9, 1966 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE S.G. Weisman					22b. DATE SIGNED 3/10/66		22c. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN		
22d. ADDRESS 59 GREENE ST. CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/11/66		23c. NAME OF CEMETERY OR CREMATORY Sunset Memo Ph		23d. LOCATION (City, town or county) (State) Cumberland Md			
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb Md					25a. REC'D BY REGISTRAR MAD 1 DATE		25b. REGISTRAR'S SIGNATURE Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03112 Item 8 film 6574 6/21/66 mb											
03097											
1. PLACE OF DEATH											
a. COUNTY Allegany				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
								a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Cumberland				2 years				Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?			
418 Fayette Street				418 Fayette Street				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)											
First Middle Last John B. La Manca											
4. DATE OF DEATH Month Day Year March 13 19 66											
5. SEX Male											
6. COLOR OR RACE White											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH 1888 Sept. 11, 1887											
9. AGE (In years last birthday) 77											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Consultant & Linguist											
10b. KIND OF BUSINESS OR INDUSTRY Government-Private											
11. BIRTHPLACE (County & State, or foreign country) Rotondella, Italy											
12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Paul F. La Manca											
14. MOTHER'S MAIDEN NAME Carmela Marie Mazzei											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no											
16. SOCIAL SECURITY NO. (If yes give war or dates of service)											
17. INFORMANT Address Mrs. Irene La Manca, Cumberland, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of larynx										INTERVAL BETWEEN ONSET AND DEATH 4 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 6 - 1, 19 65 to 3 - 13, 19 66, that (I) (we) last saw the deceased alive on 3 - 13, 19 66, and that death occurred at 7p M, from the causes and on the date stated above.											
22a. SIGNATURE George W. Ballin M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22b. DATE SIGNED 3-15-1966											
22c. PHYSICIAN'S NAME (Type) Dr. Ralph W. Ballin, M.D.											
22d. ADDRESS 62 Greene St., Cumberland, Md. 21502											
23a. BURIAL CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF March 16, 1966											
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park											
23d. LOCATION (City, town or county) (State) Cumberland, Md.											
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.											
25a. REC'D BY REGISTRAR DATE MAR 18 1966											
25b. REGISTRAR'S SIGNATURE J Charles Judge											

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03113

03098

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Somerset</u>	
c. LENGTH OF STAY IN TB <u>Since 7/3/64</u>		d. STREET ADDRESS <u>Somerset</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kinch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Idella</u> Last <u>Landis</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 15, 1877</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u> Hours <u>19</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Somerset Co. Pennsylvania</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13. FATHER'S NAME <u>William Foust</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Brant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Emmons Landis, Hazen Rd. Route 2, Cumberland Md</u>	
17. INFORMANT <u>Emmons Landis, Hazen Rd. Route 2, Cumberland Md</u>		Address <u>Emmons Landis, Hazen Rd. Route 2, Cumberland Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Ischemia</u> 4 in 21 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial Ischemia</u> (c) <u>Arteriosclerosis</u> cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 mos.</u> <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 10, 1966</u> to <u>Mar. 11, 1966</u> that (I) (we) last saw the deceased alive on <u>Mar. 10, 1966</u> and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Clayton L. Lurrett</u>		22b. DATE SIGNED <u>Mar. 11, 1966</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 13, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Near Garrett, Penna.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stafer</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1966</u>	
ADDRESS <u>230 Balto Ave., Cumberland, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

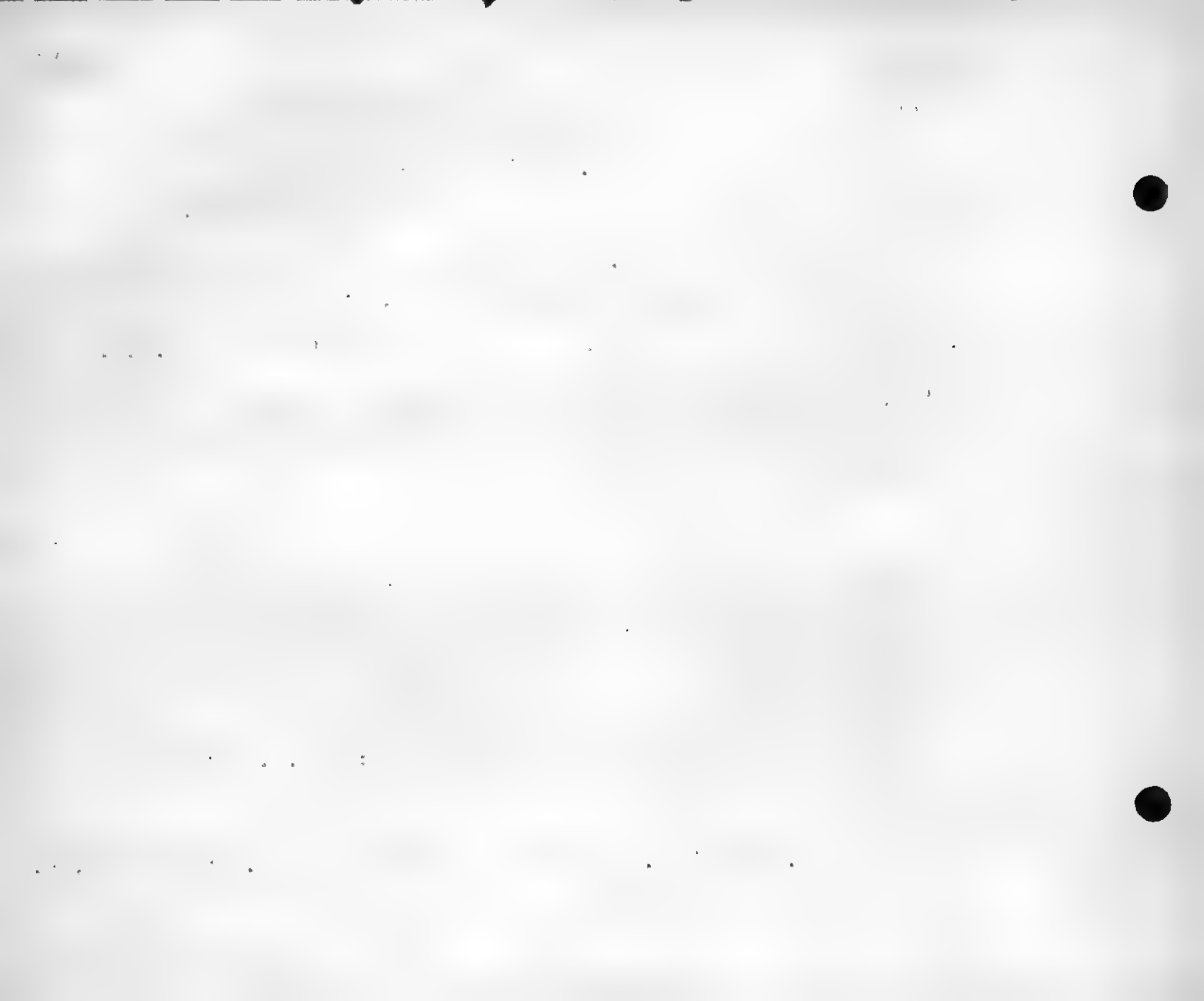


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They must remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03114					03099						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY ALLEGANY					a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					b. COUNTY ALLEGANY						
c. LENGTH OF STAY IN 1b 6 HRS. 35 MIN					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 600 LOUISIANA AVE.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
First Middle Last MARGARET A. LANHAM			Month Day Year MARCH 12 19 66			FEMALE			WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH MARCH 10, 1907			9. AGE (In years less birthday) 59			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM HAHN					14. MOTHER'S MAIDEN NAME HATTIE PARSONS						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO. 277-22-4924		17. INFORMANT Address MEMORIAL HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction										6 AM.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Coronary Occlusion										6 AM.	
DUE TO (c) Coronary Arteriosclerosis										??	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial fibrosis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-12-66 , 2:50 P.M. to 3/12 19 66 , that (I) (we) last saw the deceased alive on 3/12/66 , and that death occurred at M , from the causes and on the date stated above.										22b. DATE SIGNED	
22a. SIGNATURE <i>Samuel M. Jacobson</i>										22c. PHYSICIAN'S NAME (Type) DR. SAMUEL M. JACOBSON	
22d. ADDRESS 50 PERSHING ST. CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Marc. 16, 1966		23c. NAME OF CEMETERY OR CREMATORY Standing Rock Cemetery			23d. LOCATION (City, town or county) (State) Kent, Ohio			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR MAR 17 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> <div style="text-align: right;"> 03100 </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN ID <u>15 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>011</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>419 Springdale Street</u>						d. STREET ADDRESS <u>419 Springdale Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Thomas</u>		Middle <u>Wesley</u>		Last <u>Lease</u>		4. DATE OF DEATH		Month <u>March</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1894</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Conductor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rawlins, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Jacob Lease</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Huff</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>War I</u>				16. SOCIAL SECURITY NO. <u>217-10-9382</u>		17. INFORMANT Address <u>Mrs. Barbara Lease, Cumberland, Md. Wife</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> (b) <u>Myocarditis & Deformation</u> (c) <u>Atherosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u>, 19<u>66</u> to <u>Mar. 10</u>, 19<u>66</u> that (I) (we) last saw the deceased alive on <u>Mar. 4</u>, 19<u>66</u>, and that death occurred at <u> </u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Clay E. Durrett</u> M.D.						22b. DATE SIGNED <u>March 11, 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dr. Clay E. Durrett, M.D.</u>						22d. ADDRESS <u>236 Virginia Ave., Cumberland, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>March 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>			23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>			
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>						25a. REC'D BY REGISTRAR <u>MAR 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03116 CERTIFICATE OF DEATH 03101											
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 26 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CRESAPTOWN d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First BLANCHE E. Middle LEE Last LEE						4. DATE OF DEATH Month MARCH Day 5 Year 1966					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 27, 1902		9. AGE (in years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HENRY JOHNSON						14. MOTHER'S MAIDEN NAME ANN DILLMAN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer metastasis 1531 DUE TO The coiled Concinoma transverse Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 2 yrs. (c)										INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 4, 1966 to Mar 5, 1966 , that (I) (we) last saw the deceased alive on Mar 4, 1966 , and that death occurred at 4:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE DR. DONALD B. GROVE						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) DR. DONALD B. GROVE			
22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.						22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/9/66		23c. NAME OF CEMETERY OR CREMATORY George Cem.		23d. LOCATION (City, town or county) (State) Swanton Md.			
24. FUNERAL DIRECTOR Westernport, Md.						25a. REC'D BY REGISTRAR MAR 10 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

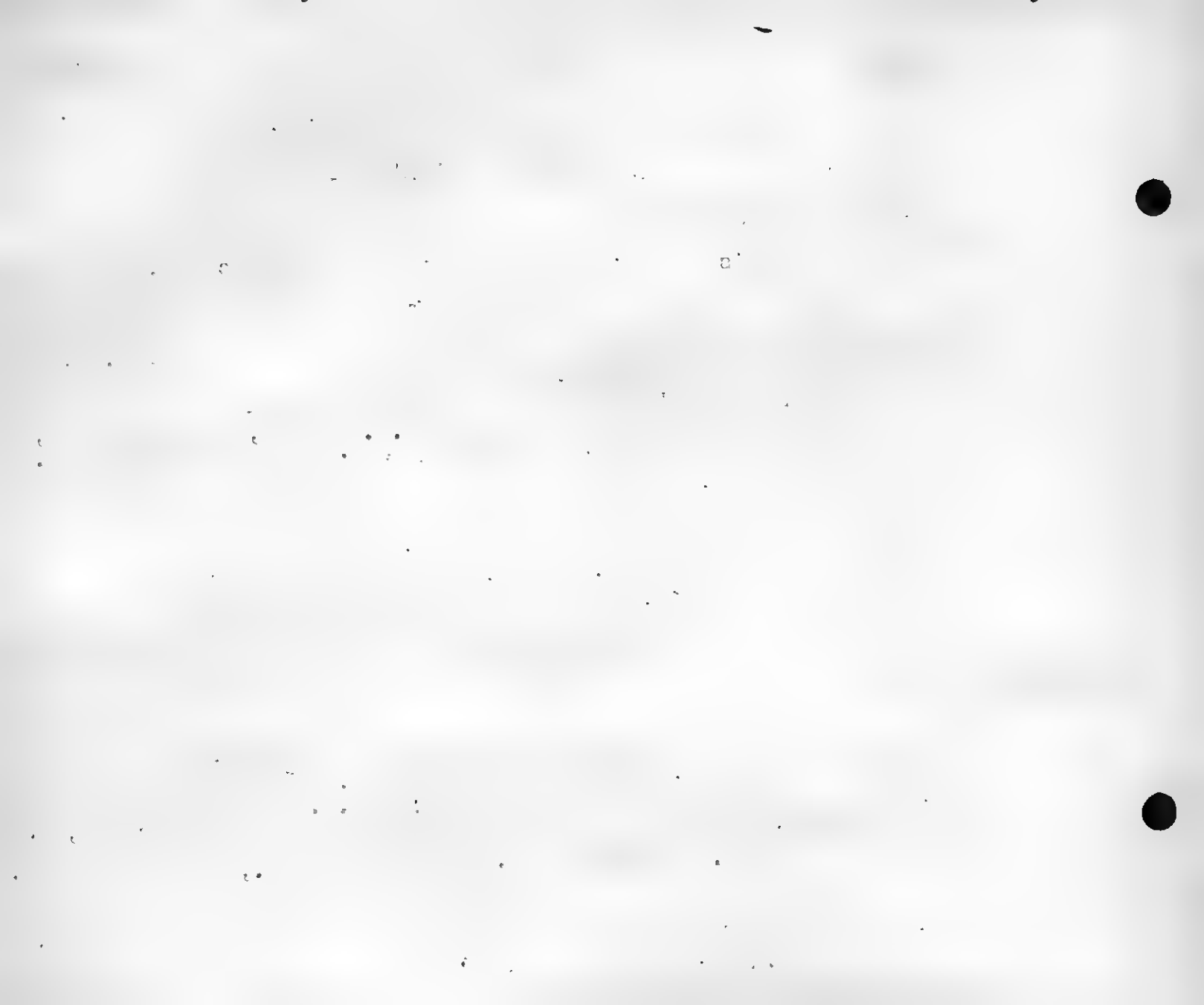


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03117					03102						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Allegany MARYLAND					a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Flintstone						
c. LENGTH OF STAY IN b. 3/14/64					d. STREET ADDRESS Route #2						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Allegany County Infirmary					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First Lewis Middle Loring Last Littlefield			4. DATE OF DEATH			Month March Day 10 Year 1966		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/26/1889		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Farmer &				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Textile Worker-Celanese Corp. James Littlefield						14. MOTHER'S MAIDEN NAME Hannah Thompson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 722-05-4750		17. INFORMANT P.O.Box 599, Cumberland, Md Address Allegany County Infirmary records.					
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Pneumonia DUE TO Myocarditis Ch. degenerative (b) Arterio Sclerosis & Hypertension DUE TO Cerebral Apoplexy of left Hemis. Placed (c) Old Fracture of left Elbow										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/14/64 , 19__, to 3/10/66 , 19__, that (I) (we) last saw the deceased alive on 3/9/66 , 19__, and that death occurred at A. M. from the causes and on the date stated above.											
22a. SIGNATURE Lee B. Mathews, M. D.						at 12:40 A.M.			22b. DATE SIGNED March 10, 1966		
22c. PHYSICIAN'S NAME (Type)						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
22d. ADDRESS 49 Greene St., Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial				March 12, 1966		Hillcrest Burial Park		Cumberland, Maryland			
24. FUNERAL DIRECTOR John F. Hafer						ADDRESS 230 Baltimore Ave., Cumberland		25a. REC'D BY REGISTRAR MAR 14 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



02118

CERTIFICATE OF DEATH

03103

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 21 National Highway	
3. NAME OF DECEASED (Type or print) Margaret Rebecca Martz		4. DATE OF DEATH Month 3 Day 2 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/96
9. AGE (In years lost birthday) 69 yrs		10. IF UNDER 1 YEAR Months 2 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Issac Stonebreaker		14. MOTHER'S MAIDEN NAME Hattie Katherine Runion	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Chester Rotruck, 275 Keys St Keyser WVa Chart		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left patient's self in bed DUE TO (b) Retropneumothorax, Cause? DUE TO (c) Shock	
PART II. SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/13, 1966 to 3/2, 1966 , that (I) (we) last saw the deceased alive on 3/1, 1966 , and that death occurred at 4:05 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Weisman		22b. DATE SIGNED 3/4/66	
22c. PHYSICIAN'S NAME (Type) Dr. Weisman		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 5, 1966	
23c. NAME OF CEMETERY OR CREMATORY Sts Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md	
24. FUNERAL DIRECTOR John F. Hafer		25a. REC'D BY REGISTRAR 1966	
25b. REGISTRAR'S SIGNATURE Judge		25c. ADDRESS 230 Balto Ave., Cumberland, Md	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 13 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 7 RACE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FORREST ^{First} W. ^{Middle} MC BEE ^{Last}		4. DATE OF DEATH MARCH ^{Month} 16 ^{Day} 19 ^{Year} 66	
5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 30, 1898 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman 10b. KIND OF BUSINESS OR INDUSTRY 340 RR.		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE MC BEE		14. MOTHER'S MAIDEN NAME NANCY HUTZLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 705-07-9516 17. INFORMANT MEMORIAL HOSPITAL Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cor. Nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Brachial Aneurysm 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/16/66 7:05 P.M. 3/16/66, that (I) (we) last saw the deceased alive on 3/16/66 19____, and that death occurred at 7:05 P.M. 3/16/66, from the causes and on the date stated above. 22a. SIGNATURE <i>[Signature]</i> 22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS 22b. DATE SIGNED 3/18/66 22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/19/66 23c. NAME OF CEMETERY OR CREMATORY Methodist Cem. 23d. LOCATION (City, town or county) (State) Brush Valley Penna		24. FUNERAL DIRECTOR Lowis Stein Inc. ADDRESS Cumberland Md 25a. REC'D BY REGISTRAR 21 1966 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Stonewick Cumberland</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sacred Heart Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> d. STREET ADDRESS <u>Rt. # 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>E</u> Last <u>Mc Clintock</u> 4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/24/00</u> 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Mobile</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hampton Mc Clintock</u> 14. MOTHER'S MAIDEN NAME <u>Anna Mae Bodden</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>202 12 1395</u> 17. INFIRMARY <u>Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u> (b) <u>Pulmonary Emphysema, Severe</u> (c) <u>Due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma - Bronchiectasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>Berlin Somerset Co. Pa.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>3-3</u> , 19 <u>66</u> , to <u>3-5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-4</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Calvin Y. Hadidian</u> 22b. DATE SIGNED <u>3-5-66</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Hadidian</u> 22d. ADDRESS <u>Dr. Hadidian</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8 Mar 66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>J.O.O.F</u> 23d. LOCATION (City, town or county) (State) <u>Berlin Somerset Co. Pa.</u>		24. FUNERAL DIRECTOR <u>Walter A. Johnson</u> 25a. REC'D BY REGISTRAR <u>Mar 9 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Walter A. Johnson</u>	

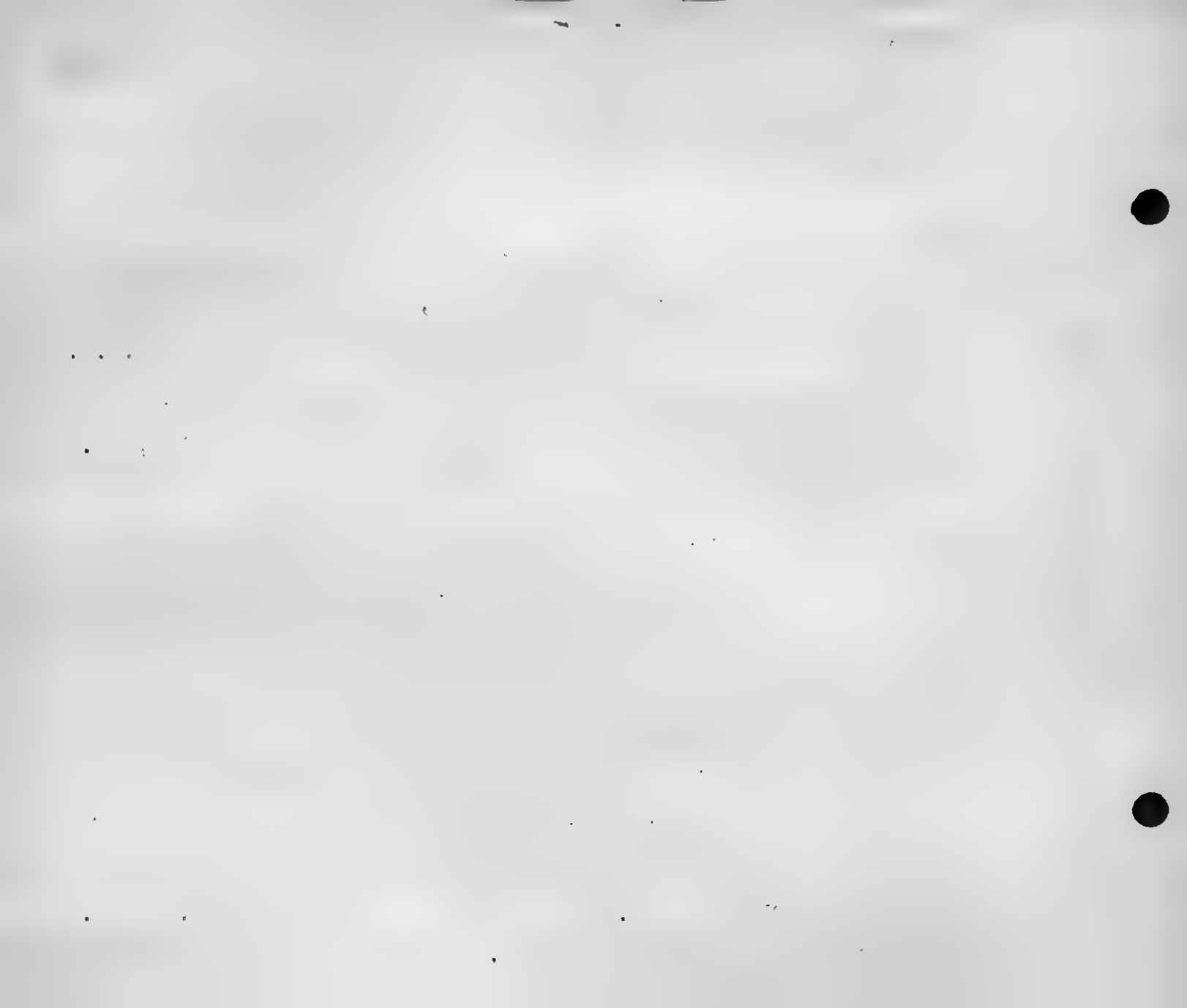


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 5-63

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03106											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lonaconing d. STREET ADDRESS Jackson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Margaret			First Middle Last McDonough			4. DATE OF DEATH March 18 19 66			Month Day Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 28, 1884		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Stakem						14. MOTHER'S MAIDEN NAME Esther Cavanaugh					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Roy McDonough		Address Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Ischemia 1951 DUE TO (b) Advanced coronary insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Atherosclerosis - generalized INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 6 mos. years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1958 to March 18, 1966 , that (I) (we) last saw the deceased alive on March 17, 1966 , and that death occurred at 8 AM , from the causes and on the date stated above.											
22a. SIGNATURE H. R. Miles, Jr. M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-18-66			
22c. PHYSICIAN'S NAME (Type) H. R. MILES, JR., M.D.						22d. ADDRESS LONA CONING, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/21/66		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City, town or county) Lonaconing, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.						25a. REC'D BY REGISTRAR MAR 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03122 CERTIFICATE OF DEATH 03107											
Item 8 Film 6575											
1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland				b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 1 week				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital				d. STREET ADDRESS 148 Bowery Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harvey Middle A. Last Miller				4. DATE OF DEATH Month March Day 25 Year 19 66							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1881 Nov. 9, 1882		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Contractor				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (County & State, or foreign country) Garrett County		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Stephen C. Miller						14. MOTHER'S MAIDEN NAME Ellen (LAST NAME UNKNOWN)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-31-9101		17. INFORMANT Address Frostburg, Md. Mrs. Harvey Miller, 148 Bowery Street,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate 177x DUE TO (b) Secondary anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH 6 mos 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-15- , 19 66 , to 3-25 , 19 66 , that (I) (we) last saw the deceased alive on 3-25 , 19 66 , and that death occurred at 4A M, from the causes and on the date stated above.											
22a. SIGNATURE H.C. Diehl				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-26-66					
22c. PHYSICIAN'S NAME (Type) H. C. Diehl, M.D.				22d. ADDRESS 39 W. Main St., Frostburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar., 27, 1966		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park Frostburg, Md.		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR HAFFER FUNERAL HOME, 60 W. MAIN ST. FROSTBURG, MD				ADDRESS FROSTBURG, MD		25a. REC'D BY REGISTRAR APR 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CS123

CERTIFICATE OF DEATH

03108

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN lb 5 1/2 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Railroad St.		d. STREET ADDRESS Railroad St.	
3. NAME OF DECEASED (Type or print) Raymond Montgomery		4. DATE OF DEATH Mar. 9 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 1, 1913
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Mill	
11. BIRTHPLACE (County & State, or foreign country) Allegany- Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Montgomery		14. MOTHER'S MAIDEN NAME Margaret Susan Beeman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert L. Montgomery-Barton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 14 Hours unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar. 9, 1966 , to Mar. 9, 1966 , that (I) (we) last saw the deceased alive on Mar. 9, 1966 , and that death occurred at 9 P.M. from causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson		22b. DATE SIGNED Mar. 11, 1966	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson		22d. ADDRESS Piedmont, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/11/66	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill	23d. LOCATION (City or Town) (County) (State) Moscow Mills Md.
24. FUNERAL DIRECTOR Ed Brul		25a. REC'D BY REGISTRAR MAR 14 1966	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH -

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03124

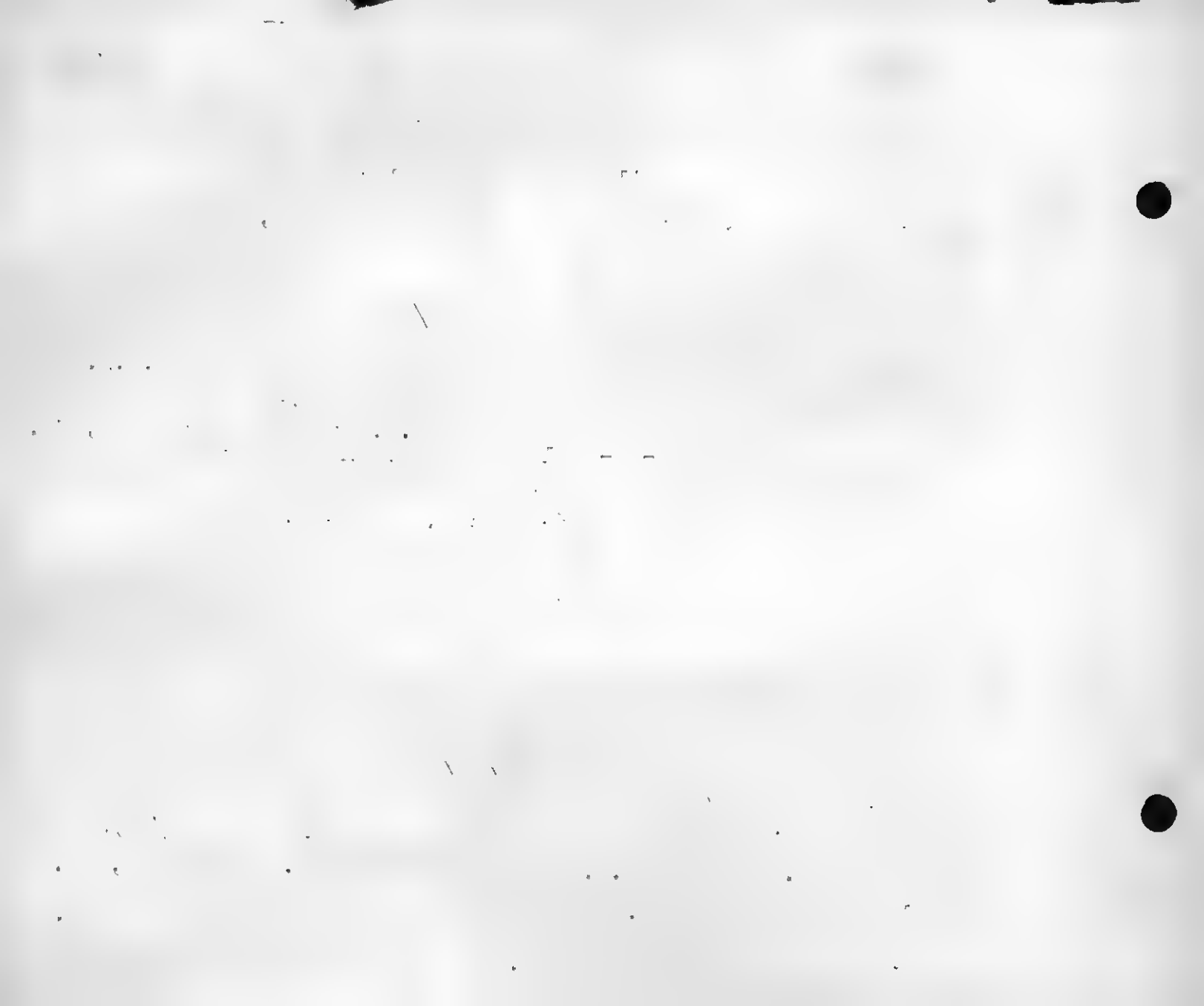
CERTIFICATE OF DEATH

03109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 11/24/65			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			d. STREET ADDRESS RFD#1, Franklin, Maryland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Regina Cordota Moran			4. DATE OF DEATH Month March Day 19 Year 1966			5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 2/26/1894			9. AGE (in years last birthday) 72 yrs.			IF UNDER 1 YEAR: Months Days Hours Min.			IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookkeeper Grocery			10b. KIND OF BUSINESS OR INDUSTRY Allegany Maryland U.S.A.			11. BIRTHPLACE (County & State, or foreign country) Allegany Maryland U.S.A.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Daniel Moran			14. MOTHER'S MAIDEN NAME Bridget Gilmore			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 232-01-1311			17. INFORMANT P.O. Box 599 Cumberland, Md. Allegany County Infirmary					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Hypertensive Chn. degenerative DUE TO (b) ② cerebral thrombosis & left hemiplegia DUE TO (c) ③ Hypertensive cardiac vascular disease DUE TO ④ Osteoarthritis, both knees																		INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 11/24/65 , 19 18 , to 3/19/66 , 19 19 , that (I) (we) last saw the deceased alive on 3/19/66 , 19 19 , and that death occurred at 9 A M, from the causes and on the date stated above.																													
22a. SIGNATURE Lee B. Mathews												22b. DATE SIGNED 3/19/66			22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M.D.			22d. ADDRESS 49 Greene St. Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 3/22/66						23c. NAME OF CEMETERY OR CREMATORY St. Peters						23d. LOCATION (City, town or county) (State) Westernport Md.											
24. FUNERAL DIRECTOR W. B. Neal												ADDRESS Westernport, Md.						25a. REC'D BY REGISTRAR DATE MAR 21 1966						25b. REGISTRAR'S SIGNATURE Charles Judge					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03110

03125

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegheny MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY in lb 58 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital		d. STREET ADDRESS 408 York Place	
3. NAME OF DECEASED (Type or print) First Robert Middle A. Last Nee		4. DATE OF DEATH Month March Day 22 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1907
9. AGE (In years, last birthday) 58 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Nee		14. MOTHER'S MAIDEN NAME Matilda O'Donnell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War II		16. SOCIAL SECURITY NO 705-09-9949	
17. INFORMANT Mrs. Sarah Nee, Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS WITH THROMBOSIS DUE TO (c) ----			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED March 22, 1966 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Cumberland, M.D. Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 25, 1966	23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.	23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25. REC'D BY REGISTRAR MAR 24 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

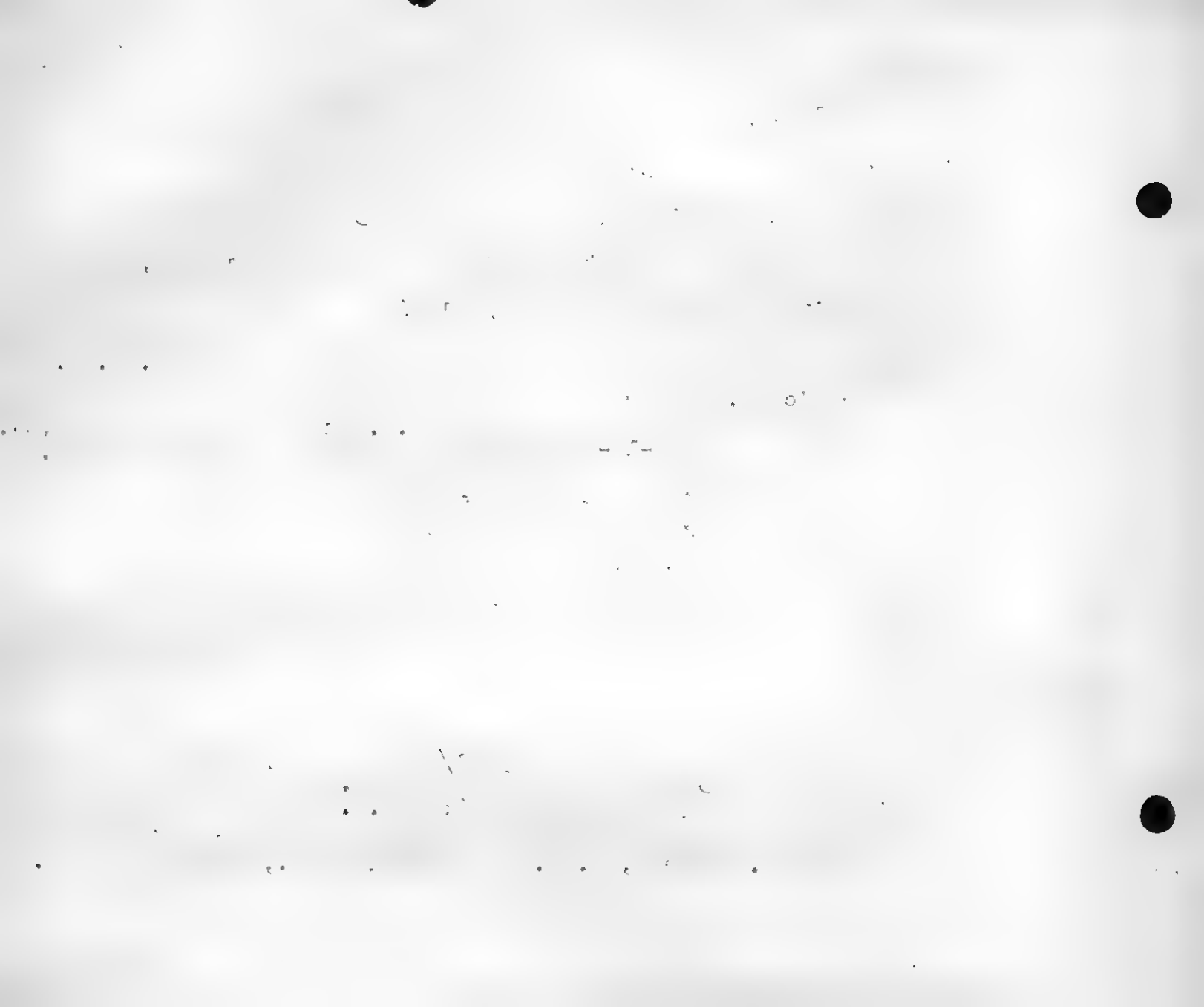
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03126

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03111

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN b. 3/21/66	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Allegany County Infirmary		e. STREET ADDRESS 213 Fulton Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Neff		4. DATE OF DEATH Month March Day 24 , Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 99 yrs.
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Merrick A. Stoner		14. MOTHER'S MAIDEN NAME Mary Anna Linn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-18-1046	
17. INFORMANT P.O. Box 599, Allegany County Infirmary records.		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Myocarditis, chr. degenerative DUE TO decompensating, Seattle (b) ② Arterio sclerosis DUE TO ③ Total Blockage (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/21/66 , 19__, to 3/24/66 19__, that (I) (we) last saw the deceased alive on 3/23/66 19__, and that death occurred at A. M., from the causes and on the date stated above.			
22a. SIGNATURE Lee B. Mathews		at 12:30 A.M. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 26, 1966	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR BYRON KIGHT		25. RECORD BY REGISTRAR MAR 30 1966	
CUMBERLAND, MD.		REGISTRAR'S SIGNATURE John Charles Judge	



03127

CERTIFICATE OF DEATH

03112

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 1803 BEDFORD ST.	
3. NAME OF DECEASED (Type or print) WILLIAM JOSEPH NEUBEISER		4. DATE OF DEATH Month MARCH Day 7 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-83
9. AGE (in years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Market (Meat)	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND, Cumberland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Neubeiser		14. MOTHER'S MAIDEN NAME Mary Kniereim	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218-24-8022	
17. INFORMANT Mr. Joseph R. Neubeiser		Address 1803 Bedford St. Cumb., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Coronary Sclerosis DUE TO (c) Carcinoma of the Prostate Gland.			INTERVAL BETWEEN ONSET AND DEATH 5 days 20 yr. 4 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis-			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. None 19 66 p.m. None	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) (County) (State) None
21. I certify that (I) (this hospital) attended the deceased from Dec. 16, 1964 to March 7, 1966 , that (I) (we) last saw the deceased alive on March 7, 1966 , and that death occurred at 9:45 AM from causes and on the date stated above.			
22a. SIGNATURE Joseph R. Neubeiser		22b. DATE SIGNED 3-9-66	
22c. PHYSICIAN'S NAME (Type) DR. HALLINAN		22d. ADDRESS 140 BEDFORD ST. CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/10/66	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR 11 1966	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

03128

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03113

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 35 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart--DOA				d. STREET ADDRESS 1314 Virginia Avenue	
3. NAME OF DECEASED (Type or print) Harry		First L.		Last Nines	
4. DATE OF DEATH March 11 1966		Month March		Day 11	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH Sept. 20, 1915		9. AGE (in years last birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman - Rest. Oper. Railroad	
11. BIRTHPLACE (State or foreign country) Davis W. Va.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ezra C. Nines	
14. MOTHER'S MAIDEN NAME Ella White		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 298-09-3713	
17. INFORMANT Mrs. Thelma Nines, Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia, Bilateral 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. 22. DATE SIGNED March 11, 1966 Address (Street, city, town, or county) Cumberland, Maryland 23a. BURIAL CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF March 13, 1966 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park 23d. LOCATION (City, town or county) (State) Cumberland, Md. 24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md. 25a. REC'D BY REGISTRAR MAR 17 1966 25b. REGISTRAR'S SIGNATURE J Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03129					03114					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE			b. COUNTY		
ALLEGANY			MARYLAND		MARYLAND			ALLEGANY		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
4 DAYS			MINERS HOSPITAL		FROSTBURG			27 FIRST STREET		
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last					Month Day Year					
JOSEPH PASSARELLI					MARCH 17, 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
MALE		WHITE				FEB. 28, 1895		71 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SELF EMPLOYED MERCHANT					GROCERY		ITALY		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
MICHAEL PASSARELLI					ROSINA ROSANOVA					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address			
YES WW 1					212-32-8042		MRS. SUSAN PASSARELLI, FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crown occlusion</i> DUE TO (b) <i>Emphysema & silicosis</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>year</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>2/17</i> , 19 <i>66</i> to <i>3/17</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>3/17</i> , 19 <i>66</i> and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.										
22a. SIGNATURE <i>John B. Davis, M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/18/66</i>		
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS						
JOHN B. DAVIS, M. D.				2 BROADWAY, FROSTBURG, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
BURIAL		MAR. 21 '66		ST. MICHAEL'S CEMETERY		FROSTBURG, MD.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
JOSEPH R. DURST, SR., FROSTBURG, MD.				MAR 21 1966		<i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>03115</p> </div> </div>										
<p>1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY</p>					
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND</p>			<p>c. LENGTH OF STAY IN 1b 4 DAYS</p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND</p>					
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL</p>					<p>d. STREET ADDRESS RT.#2, BALTIMORE PIKE</p>			<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		
<p>3. NAME OF DECEASED (Type or print) First HOWARD Middle PERRIN Last PERRIN</p>			<p>4. DATE OF DEATH Month MARCH Day 14 Year 19 66</p>							
<p>5. SEX MALE</p>		<p>6. COLOR OR RACE WHITE</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH FEB. 29, 1884</p>		<p>9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min. <input type="checkbox"/></p>		
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter - Self Employed</p>			<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (County & State, or foreign country) PENNA.</p>			<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>		
<p>13. FATHER'S NAME FRANKLIN PERRIN</p>					<p>14. MOTHER'S MAIDEN NAME ELIZABETH FELTON</p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)</p>			<p>16. SOCIAL SECURITY NO. 220-10-4560</p>		<p>17. INFORMANT Address MEMORIAL HOSPITAL</p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage SIX DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c)</p>								<p>INTERVAL BETWEEN ONSET AND DEATH 4 days</p>		
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>								<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>						
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.</p>			<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from 3-20-66 4:15 P.M. to 3-14-1966, that (I) (we) last saw the deceased alive on 3-14-1966, and that death occurred at 3-14-1966 M, from the causes and on the date stated above.</p>										
<p>22a. SIGNATURE Wm. J. Williams M.D.</p>					<p>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>		<p>22b. DATE SIGNED 3-15-66</p>			
<p>22c. PHYSICIAN'S NAME (Type) DR. W. J. WILLIAMS</p>					<p>22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.</p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF 3/17/66</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park</p>			<p>23d. LOCATION (City, town or county) (State) Cumberland Maryland</p>			
<p>24. FUNERAL DIRECTOR Ruth E. Silcox</p>					<p>ADDRESS Cumberland Maryland 21502</p>		<p>25a. REC'D BY REGISTRAR MAR 18 1966</p>		<p>25b. REGISTRAR'S SIGNATURE J. Charles Judge</p>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

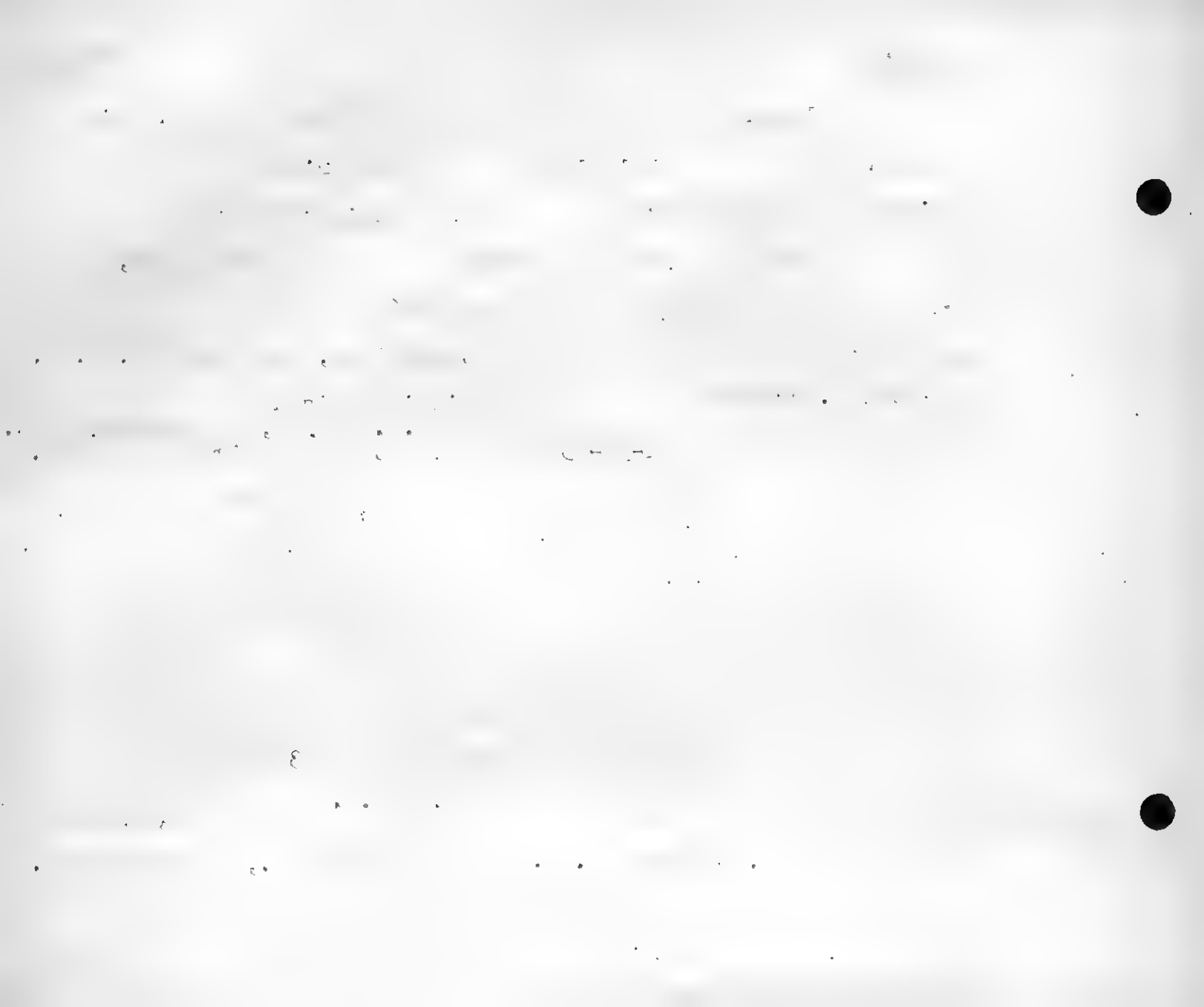
03131

03116

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1/18/1965			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Allegany County Infirmary				d. STREET ADDRESS 804 Washington Street			
3. NAME OF DECEASED (Type or print) Susanna Allison Peters				4. DATE OF DEATH Month March Day 25 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/8/1886	
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elvin E. Schartel				14. MOTHER'S MAIDEN NAME Minnie Allison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 212-32-8304		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Myocarditis, chr. degenerative + d d l DUE TO (2) Atherosclerosis, general & cerebral (3) Cerebral apoplexy, Rt. Hemiplegia DUE TO (4) Atherosclerosis of coronary artery & gangrene of Rt. hand & fingers (5) Parkinson's Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/18/65 , 19__, to 3/25/66 , 19__, that (I) (we) last saw the deceased alive on 3/24/66 , 19__, and that death occurred at A M, from the causes and on the date stated above.							
22a. SIGNATURE Lee B. Mathews				22b. DATE SIGNED 3/25/1966		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		3/28/66		Hillcrest Burial Pl.		Cumberland Md	
24. FUNERAL DIRECTOR Lewis Stein Inc. Cumb. Md.				25a. REC'D BY REGISTRAR MAR 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY CAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03117

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing c. LENGTH OF STAY IN It 75 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Front Street				2. USUAL RESIDENCE (Where deceased lived, if not in hospital; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing d. STREET ADDRESS Front Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) MARY ESTELLA PHILLIPS		4. DATE OF DEATH Month 3 Day 18 Year 1966		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/9/1890		9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 10 Days 9		11. IF UNDER 24 HRS. Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Lonaconing, MD.				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME David Mackay				14. MOTHER'S MAIDEN NAME Rosa May Allen													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Patrick McDonough, Lonaconing, MD. (Daughter)									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CORONARY SCLEROSIS (c) ---																INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 3/18/1966	
EXAMINER'S NAME (Type) Benedict Skitarelic				Cumberland, MD.				Address (Street, City, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/21/1966				22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery				22d. LOCATION (City, town, or country) (State) Lonaconing, MD.					
23. FUNERAL DIRECTOR GEORGE EICHHORN				ADDRESS Lonaconing, MD.				24a. REC'D BY REGISTRAR MAR 23 1966				24b. REGISTRAR'S SIGNATURE Charles Judge					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03133

CERTIFICATE OF DEATH

03118

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN Tb 2 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Evelyn Nisbit Piper		4. DATE OF DEATH Month Day Year 3 2 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/26/07
9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Millard Fowler	
14. MOTHER'S MAIDEN NAME Louise Kemp		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 338-12-5490		17. INFORMANT Chart Simon F. Piper, Oldtown, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dental coronary occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-28 , 19 66 , to 3-2 , 19 66 , that (I) (we) last saw the deceased alive on 3-1 , 19 66 , and that death occurred at 3-2 M, from causes and on the date stated above.			
22a. SIGNATURE Leni Brings		22b. DATE SIGNED 3-4-66	
22c. PHYSICIAN'S NAME (Type) Dr. L. Brings		22d. ADDRESS 57 Greene Street	
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE THEREOF March 5, 1966	23c. NAME OF CEMETERY OR CREMATORY Oldtown Methodist Cem.	23d. LOCATION (City or Town) (County) (State) Oldtown, Allegany Md.
24. FUNERAL DIRECTOR John J. Hafer		25a. REC'D BY REGISTRAR APR 7 1966	
25b. REGISTRAR'S SIGNATURE J. Hafer		25c. ADDRESS 230 Balto Ave., Cumberland, Md	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03134 CERTIFICATE OF DEATH					03119					
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W. VA. b. COUNTY MINERAL ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 25 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILEY FORD					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) VIRGINIA		First Middle Last BELLE POWELL		4. DATE OF DEATH Month MARCH Day 1 Year 19 66						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-29-1883		9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) West Virginia Mo.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME GEORGE SAVILLE					14. MOTHER'S MAIDEN NAME ANNA SHANHOLTZ					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - Aorta 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3rd Degree Heart Block - Fibriation (c) Arteriosclerotic Chronic Vascular Disease								INTERVAL BETWEEN ONSET AND DEATH Hours Days Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetic Mellitus								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1954 , 19 to March , 19 66 , that (I) (we) last saw the deceased alive on March 1 , 19 66 and that death occurred at 3:50 AM from the causes and on the date stated above.										
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/2/66				
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT				22d. ADDRESS 133 VIRGINIA AVE.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 3, 1966		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland Md.				25a. REC'D BY REGISTRAR MAR 4 1966		25b. REGISTRAR'S SIGNATURE [Signature]				

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03135						CERTIFICATE OF DEATH						03120	
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 35 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VIRGINIA b. COUNTY HAMPSHIRE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW d. STREET ADDRESS BOX 245 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle H. Last ROUZEE			4. DATE OF DEATH Month MARCH Day 11 Year 19 66										
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-1892		9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) RIVERTON, W. VA.			12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME GEORGE ROUZEE						14. MOTHER'S MAIDEN NAME MARY E. FISHER							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Arteriosclerosis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Prostatitis Suggestion of Malignancy 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH Sudden years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 6-4-1965 to 3-11-1966 , that (I) (we) last saw the deceased alive on 3-11-1966 and that death occurred at 12:00 P.M. from the causes and on the date stated above.													
22a. SIGNATURE W. F. Williams M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-12-66					
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS						22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)					
BURIAL		#3/14/66		Camp Hill Cem.				Paw Paw, W. Va.					
24. FUNERAL DIRECTOR Johnson Funeral Homes Berkeley Spgs.						25a. REC'D BY REGISTRAR W. F. S. 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

20
BERLAND, MD

, W. Va.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03136

03121

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Allegheny

MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)

Cumberland,

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence b form admission)

a. STATE

Maryland

b. COUNTY

Allegheny

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland,

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)

D. O. A. Sacred Heart Hosp.

d. STREET ADDRESS

212 Decatur St.

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Lawrence

Wilson

Schoonover

4. DATE OF DEATH

Month

Day

Year

March

20,

1966

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

May 27, 1939

9. AGE (In years last birthday)

26 yrs.

IF UNDER 1 YEAR: Months Days Hours Min.
IF UNDER 24 HRS: Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Attendant

10b. KIND OF BUSINESS OR INDUSTRY

Auto Service Station Elkins, W. Va.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Della G. Schoonover

14. MOTHER'S MAIDEN NAME

Dora E. Louk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes, 1956-1958

16. SOCIAL SECURITY NO.

214-36-6299

17. INFORMANT

Address

Mrs. Mary J. Schoonover 212 Decatur St. Cumb. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CRUSHED SKULL, FRACTURED NECK

INTERVAL BETWEEN ONSET AND DEATH
SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

(PASSENGER IN SINGLE AUTO ACCIDENT)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

PASSENGER IN SINGLE AUTO ACCIDENT

20c. TIME OF INJURY Month, Day, Year

11:10 p.m. March 20 1966

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

RT. 28, 2 mile south, Wiley Ford, Mineral, W. Va.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Benedict Skitarelic

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

BENEDICT SKITARELIC, M.D.

DEPUTY MEDICAL EXAMINER ☒ March 20, 1966

Address (Street city town, or county) Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

3/24/66

22c. NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

22d. LOCATION (City, town, or country)

Cumberland, Maryland

23. FUNERAL DIRECTOR

ADDRESS

H. Wayne George Cumberland, Maryland

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

MAR 28 1966

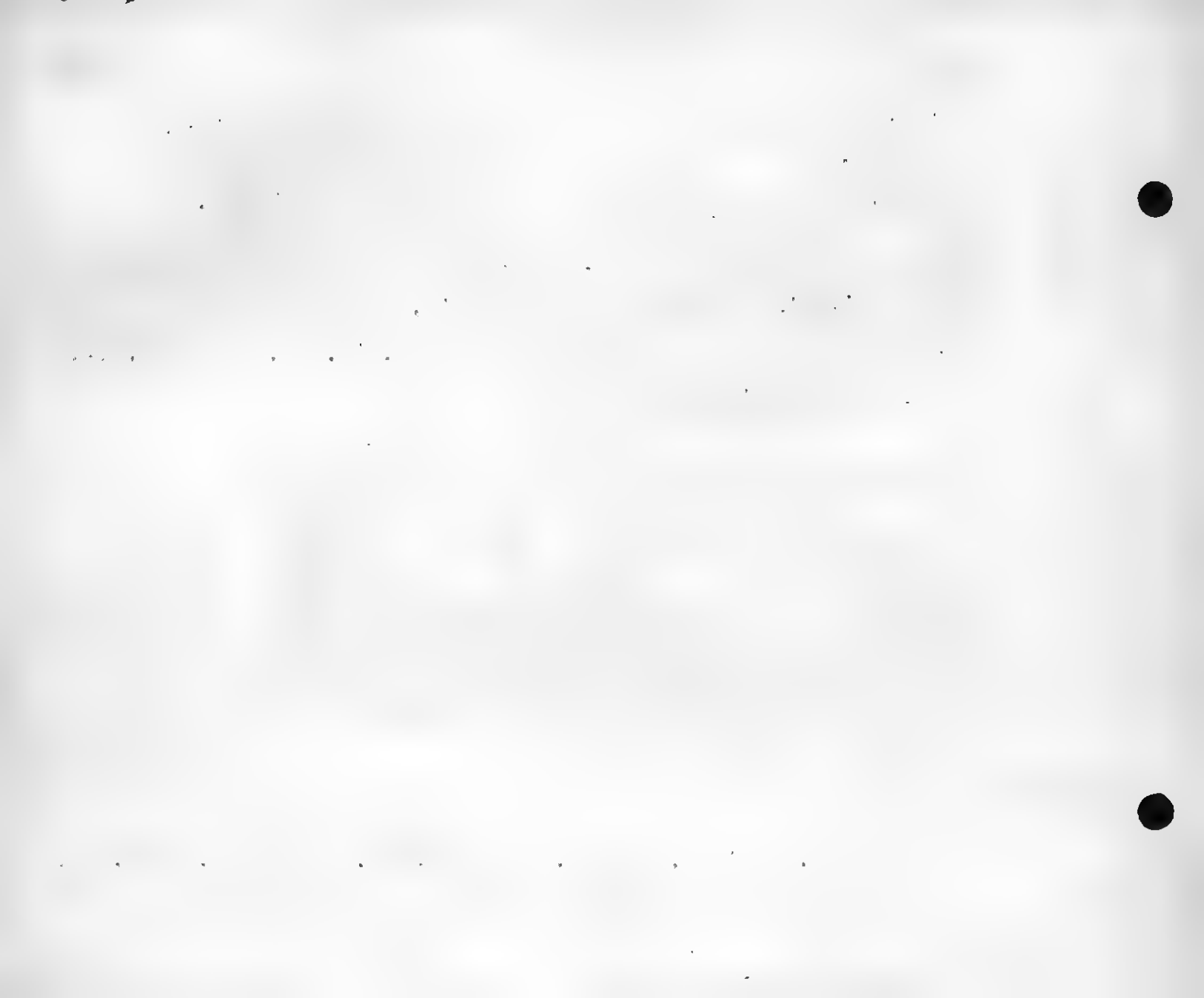
Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
031137 CERTIFICATE OF DEATH 03122									
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 38 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 202 SPRINGDALE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) GLADYS L. SCOTT			4. DATE OF DEATH MARCH 19 19 66						
5. SEX WHITE		6. COLOR OR RACE FEMALE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 905 MAY 18, 1906		9. AGE (In years last birthday) 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) ALLEG. CO. MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ULYSSES MC KENZIE					14. MOTHER'S MAIDEN NAME ORA HINES				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT MEMORIAL HOSPITAL Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) metastasis liver and lungs and DUE TO (c) terminal cachexia								INTERVAL BETWEEN ONSET AND DEATH 2 yr + 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 1966 , to March 19, 1966 , that (I) (we) last saw the deceased alive on March 19 1966 , and that death occurred at 1055 AM , from the causes and on the date stated above.									
22a. SIGNATURE Wylie M Faw Jr				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 19 1966			
22c. PHYSICIAN'S NAME (Type) DR. WYLIE M. FAW JR.				22d. ADDRESS 122 S. CENTRE ST. CMMB. MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-22-1966		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR MAR 22 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	



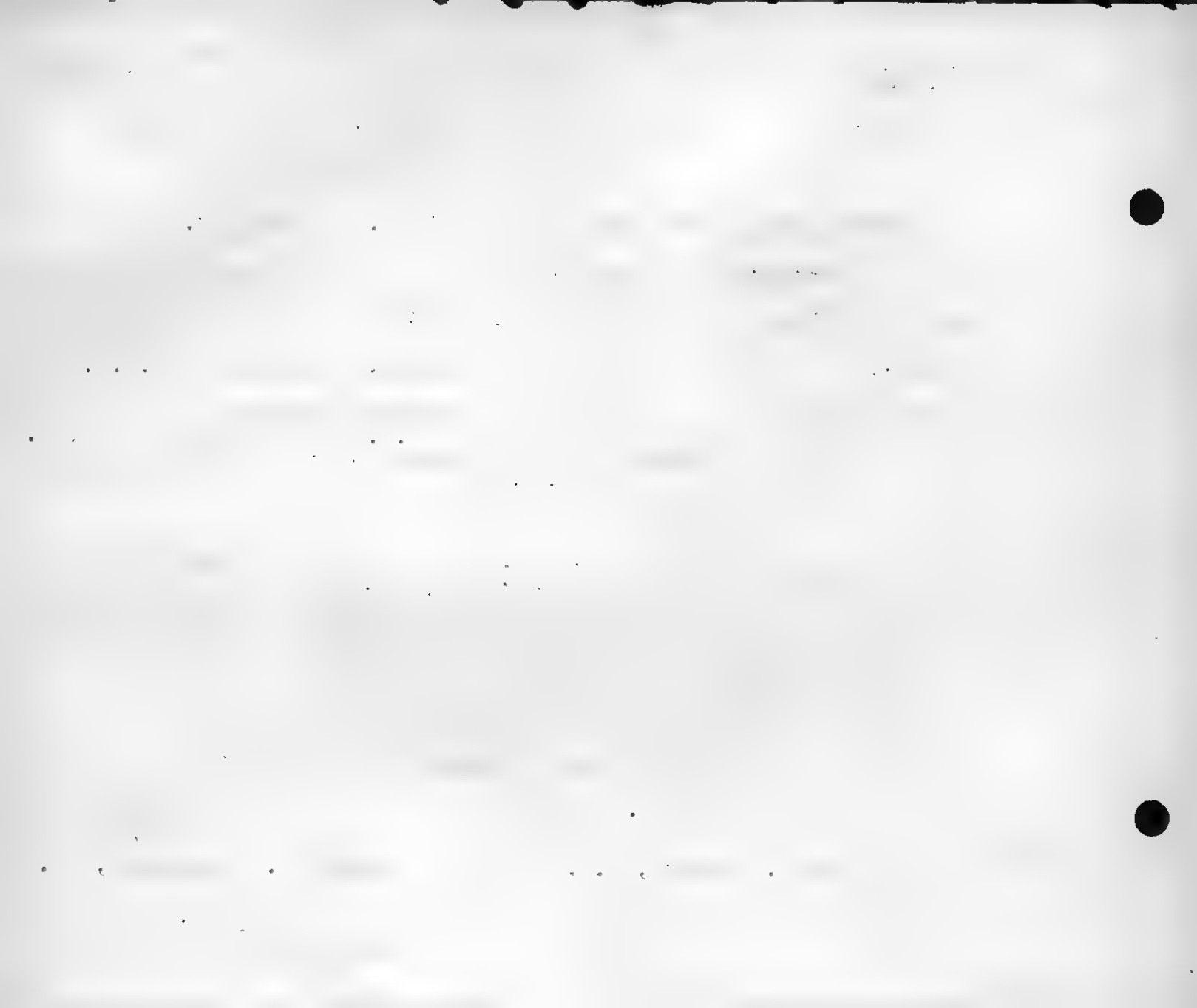
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1

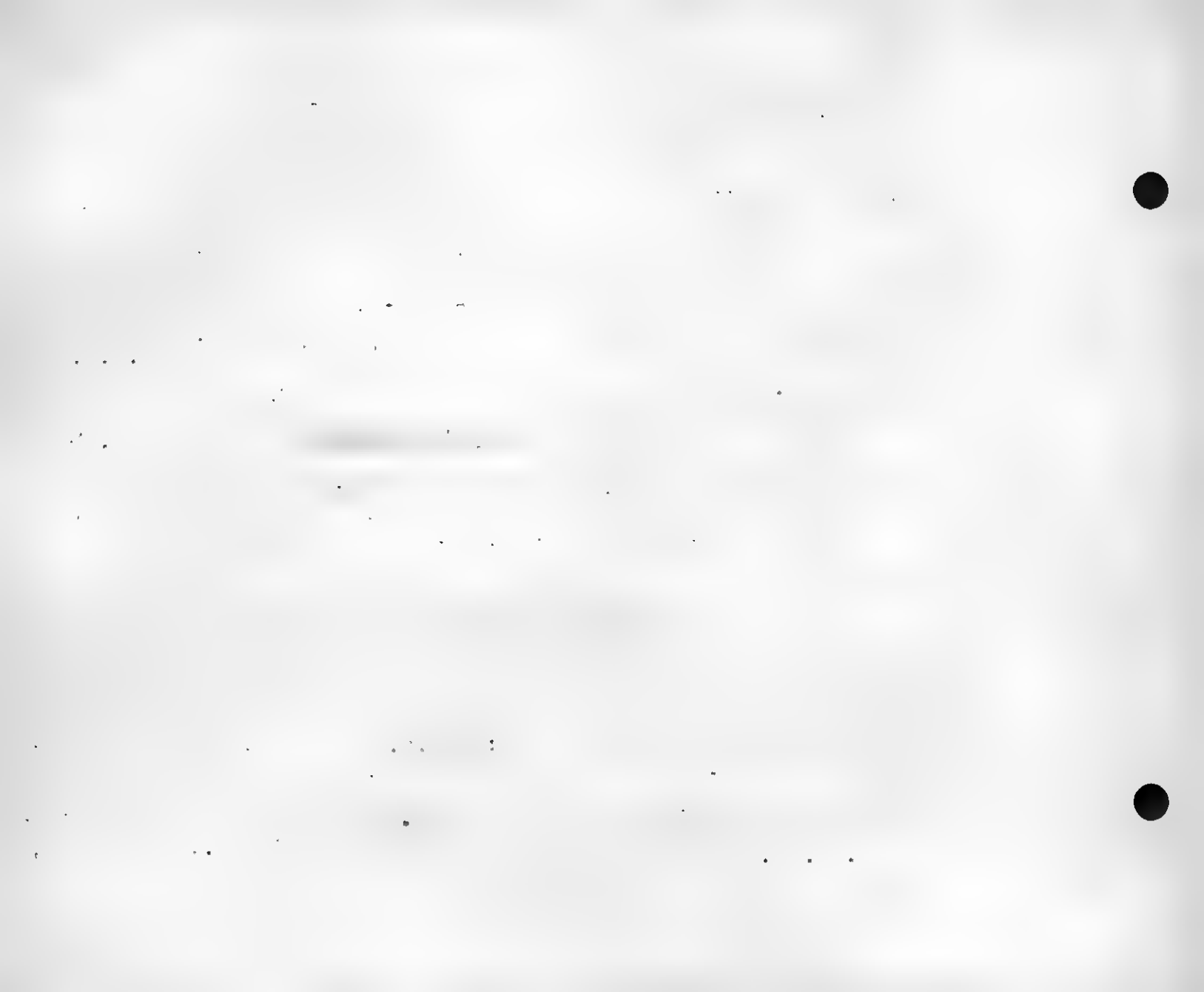
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03138		03123									
1. PLACE OF DEATH a. COUNTY Allegany						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN ID 11/3/65		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Allegany County Infirmary						d. STREET ADDRESS 121 N. Allegany St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret			First Marvin			Middle Shaw			Last		
4. DATE OF DEATH March			Month 17			Day 19			Year 66		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/12/1881		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegany Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Perry Weimer						14. MOTHER'S MAIDEN NAME Catherine Zebach					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. None		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, aka degenerative 4/1/1 DUE TO to congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic senile general atherosclerosis DUE TO to marked cerebral arteriosclerosis & Parkinson's Disease (c) to marked cerebral arteriosclerosis & Parkinson's Disease										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/3/65 to 3/16/66 , 19 66 , that (I) (we) last saw the deceased alive on 3/16/66 , 19 66 , and that death occurred at 2 A M, from the causes and on the date stated above.											
22a. SIGNATURE Lee B. Mathews, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M.D.						22d. ADDRESS 49 Greene St. Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 19, 1966		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY				23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.			
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR MAR 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03139 CERTIFICATE OF DEATH 03124									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 214 SOUTH LEE STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADA Middle MAY Last SHORT			4. DATE OF DEATH Month MARCH Day 11 Year 1966						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-2-1882		9. AGE (In years last birthday) 84 yrs. 1 month 1 day 1 hour 1 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Mineral Co. WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH PYLES					14. MOTHER'S MAIDEN NAME ELIZABETH DOWDEN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ernest Evans Address 214 South Lee St - CUMBERLAND, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Palsy - Myoclonic Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cerebrovascular Disease DUE TO (c) Diabetic Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Mellitus								INTERVAL BETWEEN ONSET AND DEATH 2 Day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1960		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5:15 P.M., 1966 to 1966 , 19, that (I) two last saw the deceased alive on 3/10/66 19, and that death occurred at 5:27 A.M. from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					22b. DATE SIGNED 3/12/66			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT					22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/14/66		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION (City, town or county) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.					25a. REC'D BY REGISTRAR 0415 MAR 15 1966		25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

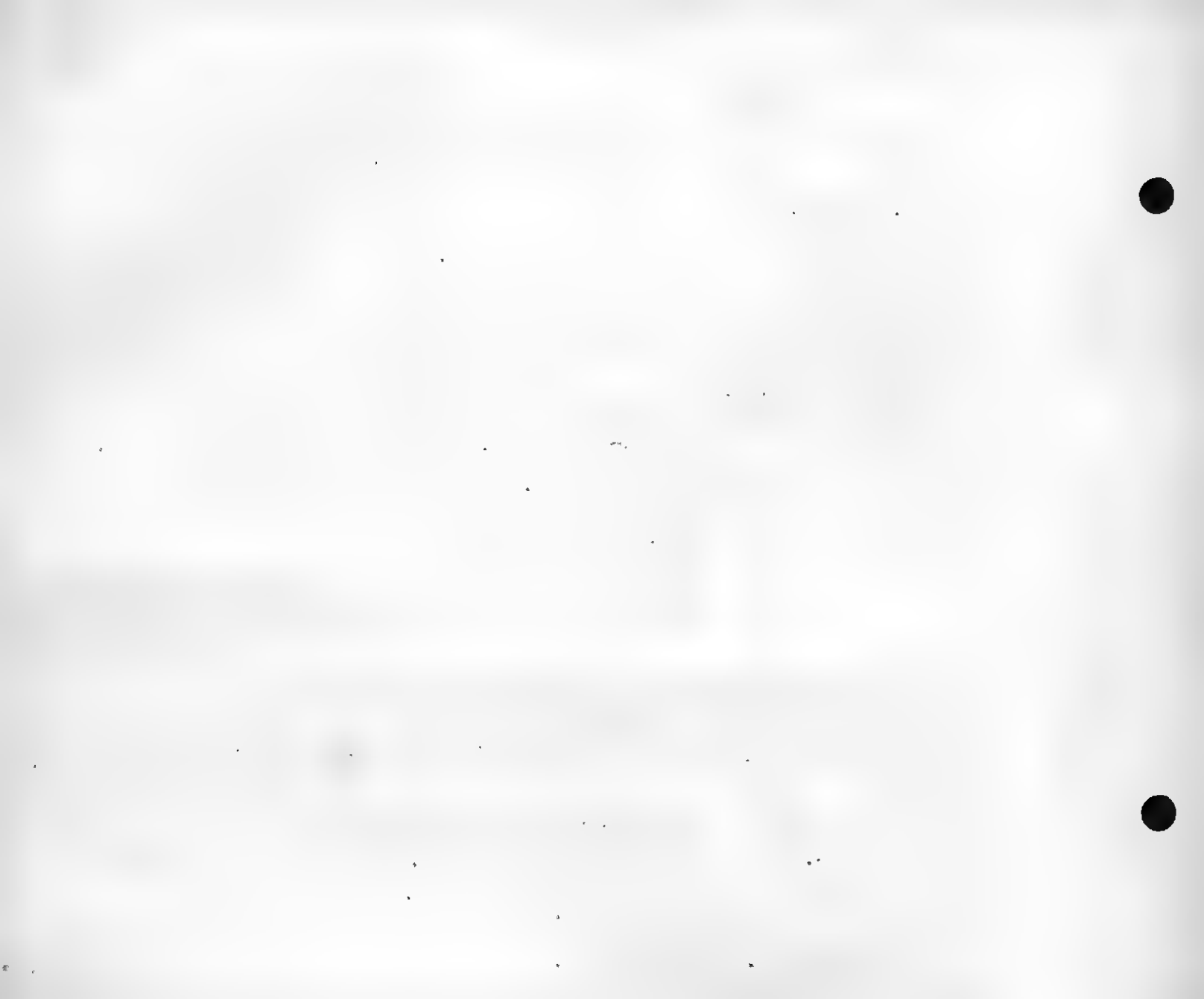
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03140

CERTIFICATE OF DEATH

03125

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL				d. STREET ADDRESS 35 BEALL STREET			
3. NAME OF DECEASED (Type or print) First LENA Middle SLINGLOFF Last SLINGLOFF				4. DATE OF DEATH Month MARCH Day 10 Year 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 3, 1898	
9. AGE (In years last birthday) 67 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSER		10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANING		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM SLINGLOFF				14. MOTHER'S MAIDEN NAME MARY WILSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-12-8152		17. INFORMANT MISS FREDA SLINGLOFF, FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary anemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-10 , 19 65 , to 3-10 , 19 66 , that (I) (we) last saw the deceased alive on 3-10 , 19 66 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
22a. SIGNATURE H. C. Diehl				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/14/66	
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.				22d. ADDRESS W. MAIN ST., FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 12, 1966		23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH P. DURST, SR., FROSTBURG, MD.				25a. REGISTERED BY MAR 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

Item 18 Film MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03126

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE,	
c. LENGTH OF STAY IN 1b 30 DAYS		d. STREET ADDRESS STAR ROUTE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle -- Last Smith		4. DATE OF DEATH Month MARCH Day 12 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 15, 1892
9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Poultry Business	
11. BIRTHPLACE (State or foreign country) BEDFORD CO. PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Smith		14. MOTHER'S MAIDEN NAME Sophia Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 195-22-1395	
17. INFORMANT Mrs. Marie Mauk, Star Rt. Flintstone, Md.		Address MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia + hyperpyrexia DUE TO Generalized Infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Unknown cause (b) Unknown cause (c) Unknown cause			INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Failure			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 12, 1966 to March 12, 1966 , that I last saw the deceased alive on March 12, 1966 , and that death occurred at 6:37 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter N. Himmler M.D. 412 N. McDonnell		DATE SIGNED 3/14/66	
PHYSICIAN'S NAME (Type) DR. WALTER N. HIMMLER		412 N. MECHANIC ST. CUMB.MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 3/15/66	22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	22d. LOCATION (City, town, or county) (State) nr. Artemas, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland		24a. REC'D BY REGISTRAR MAR 17 1966	24b. REGISTRAR'S SIGNATURE John Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03142					03127					
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYNDMAN, PA.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS RT.#1, BOX 4			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS J. SNYDER			4. DATE OF DEATH Month Day Year MARCH 9 1966							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 7, 1878		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min. 88		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (County & State, or foreign country) EVERETT, PA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Arthur A. Snyder					14. MOTHER'S MAIDEN NAME SUSANNA WALKER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 1.0			16. SOCIAL SECURITY NO. 705-03-6308		17. INFORMANT Address MEMORIAL HOSPITAL					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial - Acute Normal Failure 6000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Chronic Pyelonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardio-Vascular disease										
19. INTERVAL BETWEEN ONSET AND DEATH 5 days 3 yrs										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6 Mar 66 6:30 P.M. 9 Mar , 19 66 , that (I) (we) last saw the deceased alive on 9 Mar 19 66 , and that death occurred at M , from the causes and on the date stated above.										
22a. SIGNATURE James B. Stegmaier					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.			22b. DATE SIGNED 10 Mar. 66		
22c. PHYSICIAN'S NAME (Type) DR. JAMES G. STEGMAIER					22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Mar. 12, 1966		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery			23d. LOCATION (City, town or county) (State) Hyndman, Bedford Co. Pa.		
24. FUNERAL DIRECTOR Harvey N. Zeigler					ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR MAR 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03143

03128

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before adm ssion) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN lb 22 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 408 Park Street			
3. NAME OF DECEASED (Type or print) First Wilbert Middle Cletus Last Snyder				4. DATE OF DEATH Month March Day 5 Year 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/7/13	9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroader (switch tender)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) Bergton, Va.		
13. FATHER'S NAME Ransom Snyder			14. MOTHER'S MAIDEN NAME Sarah Smith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 1		17. INFORMANT Patient's chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Coma 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cirrhosis of the liver DUE TO (c) approx 3 yrs				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/11/66 , 19 66 , to 3/5 , 19 66 that (I) (we) last saw the deceased alive on 3/5 19 66 , and that death occurred at 4 P.M. from causes and on the date stated above.							
22a. SIGNATURE W. Spiggle				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/5/66	
22c. PHYSICIAN'S NAME (Type) W. Spiggle				22d. ADDRESS 126 N Smallerwood, Cumberland Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/66		23c. NAME OF CEMETERY OR CREMATORY Tomahawk Cemetery		23d. LOCATION (City or Town) (County) (State) Hedgesville, West Virginia	
24. FUNERAL DIRECTOR John F. Hofer				25a. REC'D BY REGISTRAR 230 Baltimore Avenue		25b. REGISTRAR'S SIGNATURE Charles Judge	

VR A15 (4)
20 M 1/66

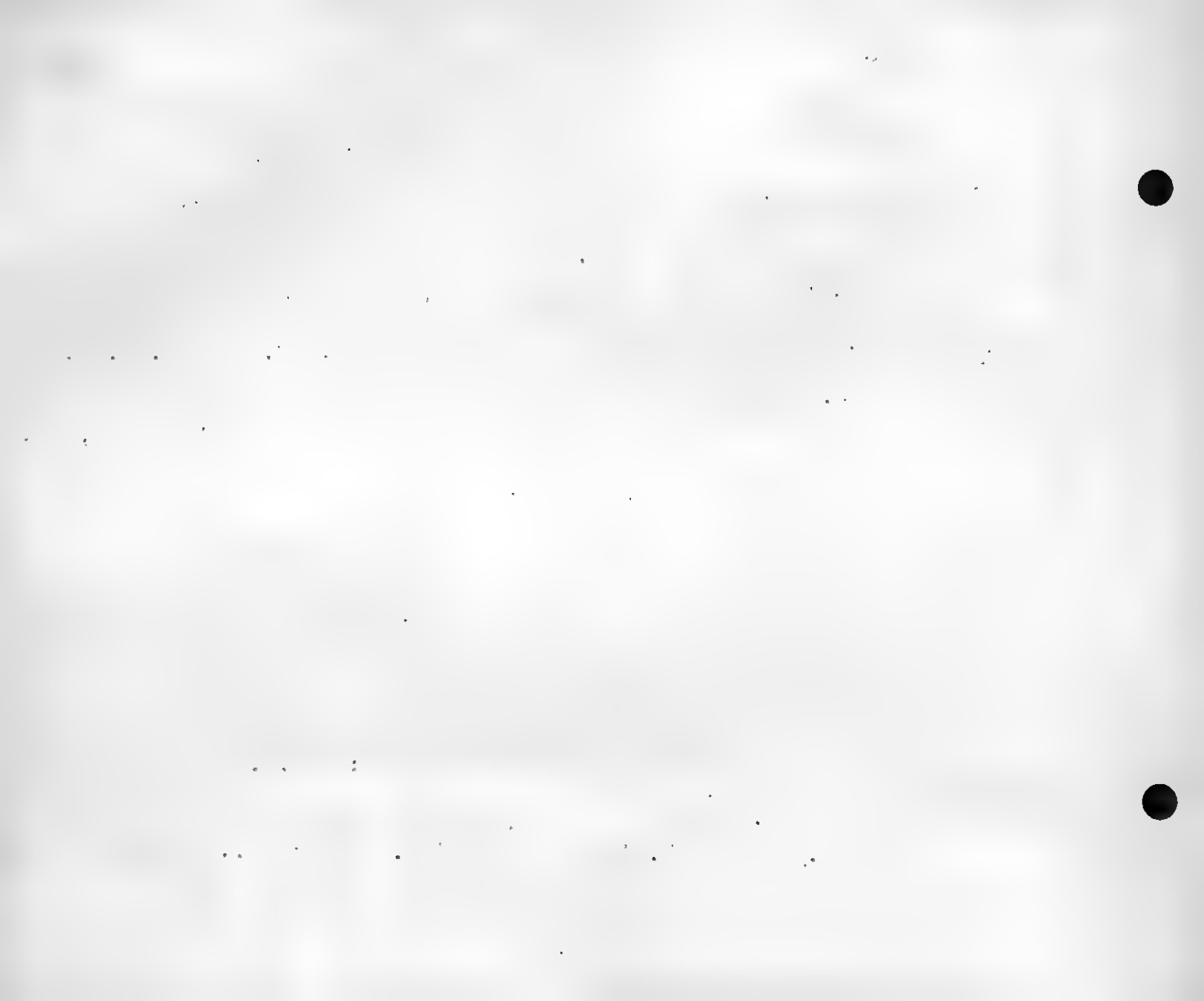
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When the permit is removed, the certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03144 CERTIFICATE OF DEATH 03129									
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 43 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 132 BEDFORD STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First CHESTER Middle D. Last SOWERS					4. DATE OF DEATH Month MARCH Day 11 Year 19 66				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-13-1898		9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pharmacist				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES J. SOWERS					14. MOTHER'S MAIDEN NAME MARGARET J. KNOTT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) -					16. SOCIAL SECURITY NO. -		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. Address 		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 251X DUE TO (b) General arteriosclerosis & hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Embolism - Perforation of Bladder								INTERVAL BETWEEN ONSET AND DEATH 4.5 d	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 		
21. I certify that (I) (this hospital) attended the deceased from 1962 , 19 3-11 to 3-11 , 19 66 , that (I) (we) last saw the deceased alive on 3-10 19 66 and that death occurred at 7:35 A.M. M, from the causes and on the date stated above.									
22a. SIGNATURE William P. James					22b. DATE SIGNED 3/14/66			22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES	
22d. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/14/66		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem		23d. LOCATION (City, town or county) (State) Cumberland MD		
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb MD					25a. REC'D BY REGISTRAR MAR 18 1966 DATE 		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 507 EAST OLDTOWN ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last STALLINGS					4. DATE OF DEATH Month MARCH Day 5 Year 1966				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28-1894		9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR: Months 7 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED -Maintenance Dept. Store				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NATHAN STALLINGS					14. MOTHER'S MAIDEN NAME ANNA Q. TWIGG				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) War I				16. SOCIAL SECURITY NO. 218-24-7875		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Thrombosis DUE TO (b) Emphysema DUE TO (c) Myocarditis (Coronary atherosclerosis)								INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs 4 yrs 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1958 to March 5, 1966 , that (I) (we) last saw the deceased alive on March 5, 1966 , and that death occurred at 11:00 p.m. from the causes and on the date stated above.									
22a. SIGNATURE Clay E. Durrett					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/6/66		
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT					22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 9, 1966		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR James F. Scarnelli, Cumberland, Md.					25a. REC'D BY REGISTRAR MAR 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

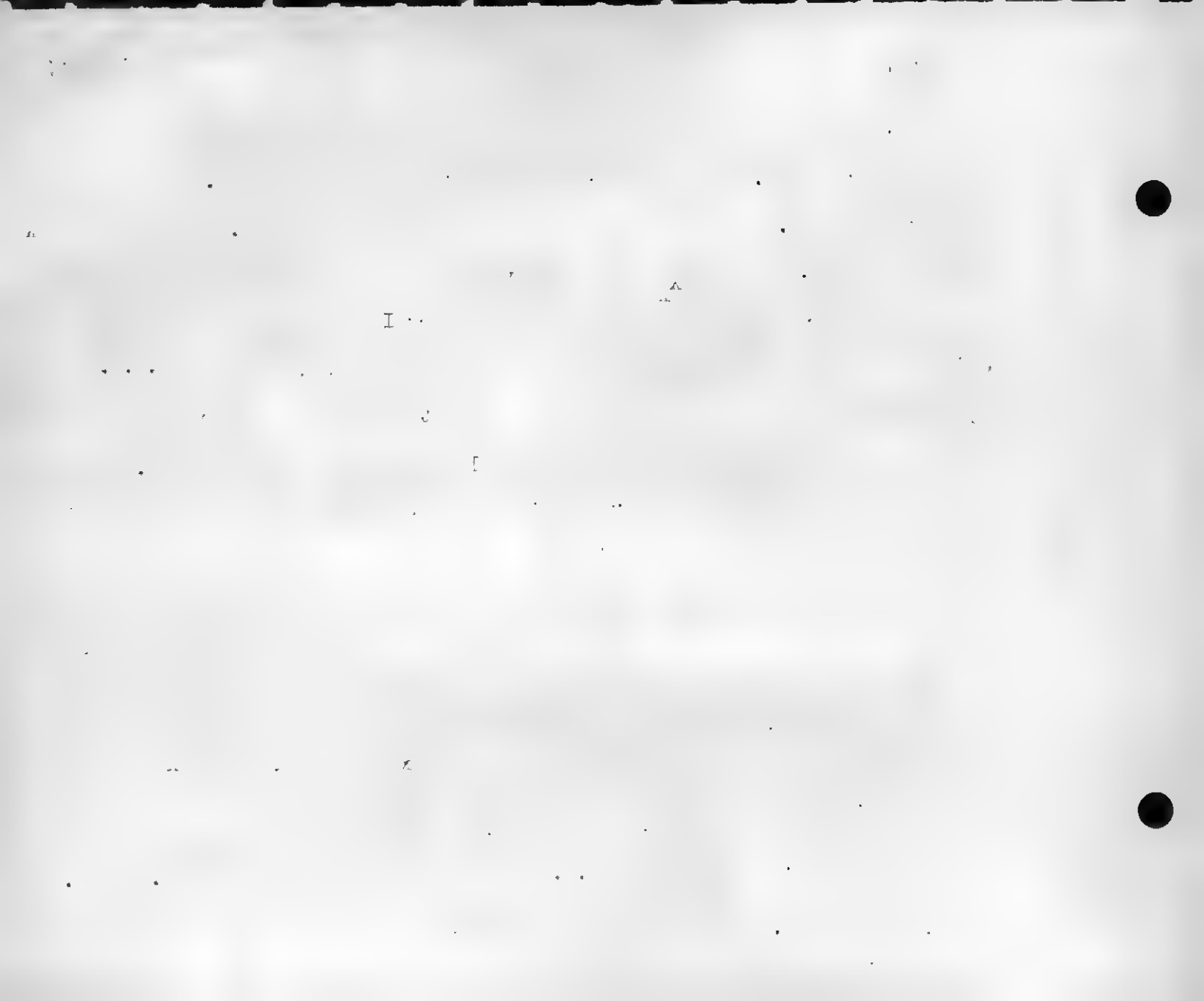
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03146

03131

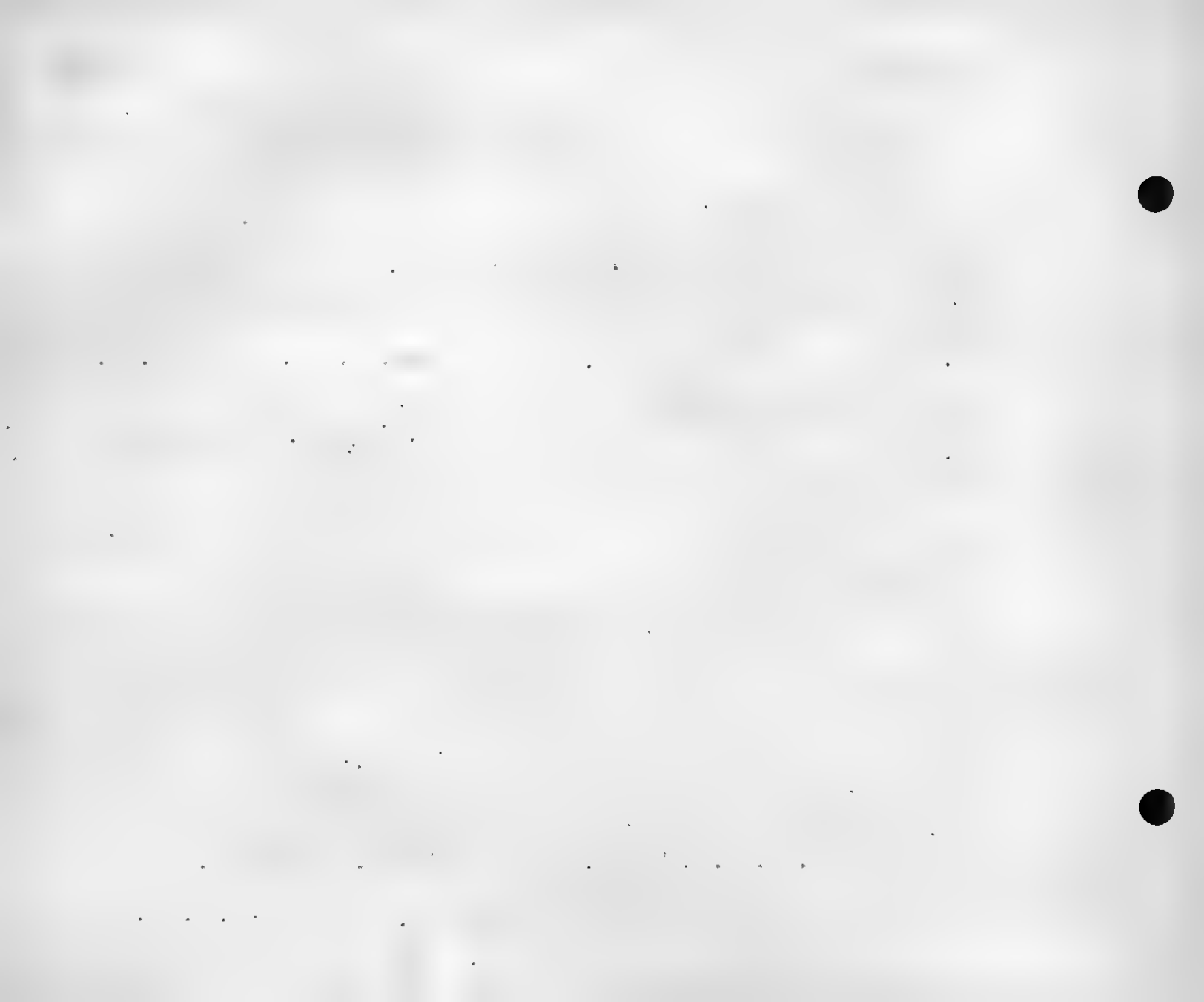
1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ellerslie Md.				c. LENGTH OF STAY IN 1b 65 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ellerslie Md.				e. STREET ADDRESS Ellerslie Md.			
3. NAME OF DECEASED (Type or print) Hugh Stevenson				4. DATE OF DEATH March 6 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 19 1882 83 yrs.	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 19	Hours 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Judge				10b. KIND OF BUSINESS OR INDUSTRY Judge Of Court		11. BIRTHPLACE (State or foreign country) Perceton Scotland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Gavin Stevenson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Janet Hymers Stevenson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized 157x Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Carcinoma of Pancreas (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH Months _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitaralic M.D.				22. DATE SIGNED March 7, 1966			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 9, 1966		23c. NAME OF CEMETERY OR CREMATORY Ross Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumberland Md.				25a. REC'D BY REGISTRAR MAR 9 1966		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN ID 11 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL</p> </div> <div> <p>2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 476 WILLIAMS ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> </div> </div>											
3. NAME OF DECEASED (Type or print) First HARRY Middle Columbus Last THOMPSON Sr.				4. DATE OF DEATH Month MARCH Day 21 Year 1966							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-10-1896		9. AGE (In years 1 of birthday) 69 yrs.		10. IF UNDER 1 YEAR 1 MONTHS 1 DAY 1 HOUR 1 MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer				10b. KIND OF BUSINESS OR INDUSTRY B & O Rwy.		11. BIRTHPLACE (Country & State, or foreign country) KERens, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JOHN THOMPSON						14. MOTHER'S MAIDEN NAME DENIZA STERMS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Hester B. Thompson Address 476 Williams St. MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 222X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerosis (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 12 days										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not-While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/20/66 , 19 to 3/21/66 , 19, that (I) (we) last saw the deceased alive on 3/20/66 , 19, and that death occurred at 3:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE R. J. Williams						22b. DATE SIGNED 3/22/66					
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS						22d. ADDRESS 122 S. CENTRE ST.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/23/66		23c. NAME OF CEMETERY OR CREMATORY Primitive Baptist Cem.		23d. LOCATION (City, town or county) (State) Montrose, W. Va.			
24. FUNERAL DIRECTOR H. Wayne George						25a. REC'D BY REGISTRAR 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

03134

03149

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 1/2 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CATHERINE Middle TRACY Last TRACY		4 DATE OF DEATH Month MARCH Day 29 Year 19 66	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-27-1907
9 AGE (In years last birthday) 58 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10b KIND OF BUSINESS OR INDUSTRY OWN HOME		11 BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
12 CITIZEN OF WHAT COUNTRY? U. S. A.		13 FATHER'S NAME HARRY HILLEARY	
14 MOTHER'S MAIDEN NAME ELSA KELLY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO 220 16 5724		17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive Heart Failure - Recurrent - Ant DUE TO (b) Chronic Myocarditis DUE TO (c) Dilated - Flaccid - Aortic Valve Disease.		INTERVA. BETWEEN ONSET AND DEATH 3 Hours.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Inter capillary Renal Sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 19 66 to March 19 66 , that (I) (we) last saw the deceased alive on March 28 19 66 , and that death occurred at 1:55 AM , from causes on and on the date stated above.			
22a. SIGNATURE DR. G. O. KIMMELWRIGHT		22b. DATE SIGNED 3/30/66	
22c. REGISTRAR'S NAME (Type) DR. G. O. KIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Mar. 31, 1966	23c NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery	23d. LOCATION (City or Town) (County) (State) Winchester Va
24 FUNERAL DIRECTOR John J. Hafer		25a. REC'D BY REGISTRAR APR 1 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

03150

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 - 1m 3:25 4/4/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03135

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b ROUTE 5,	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XXXXXX Sacred Heart Hospital D.O.A.		d STREET ADDRESS 4 Westwood Rd.	
3 NAME OF DECEASED (Type or print) First Nicholas Middle D Last Vlachos		4 DATE OF DEATH Month March Day 26 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-18-1919
9 AGE (n years) 47 yrs.		10 UNDER 1 YEAR Months 1 Days 26 Hours 16 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPT. PROPOSAL DEPT.		10b. KIND OF BUSINESS OR INDUSTRY ABL	
11. BIRTHPLACE (State or foreign country) PENNA		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NICHOLAS P. VLACHOS		14. MOTHER'S MAIDEN NAME MARY DAILEY	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2		6 SOCIAL SECURITY NO 149 03 9215	
17 INFORMANT EDNA H. VLACHOS, ROUTE 5, CUMBERLAND, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED March 26, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF MARCH 30, 1966	
23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D. C.	
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR MAR 30 1966	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03151

CERTIFICATE OF DEATH

03136

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 115 625 Fairview Ave.	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last White		4. DATE OF DEATH Month 3 Day 22 Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-86
9. AGE (In years lost birthday) y/s. 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laundry Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) MARYLAND (Allegany Co)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George White		14. MOTHER'S MAIDEN NAME Cynthia Hoenicka	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-10-9301A	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Vascular Accident (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/21 , 19 66 to 3/22 , 19 66 , that (I) (we) lost saw the deceased alive on 3/22 , 19 66 , and that death occurred at 4:15 M, from causes and on the date stated above.			
22a. SIGNATURE Leo H. Ley		22b. DATE SIGNED 3/25/66	
22c. PHYSICIAN'S NAME (Type) DR. LEO LEY		22d. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/25/66	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR Ruth E. Silcox		25a. REC'D BY REGISTRAR MAR 28 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100

100

100



100

100



100

100

100

100

100

TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

03152

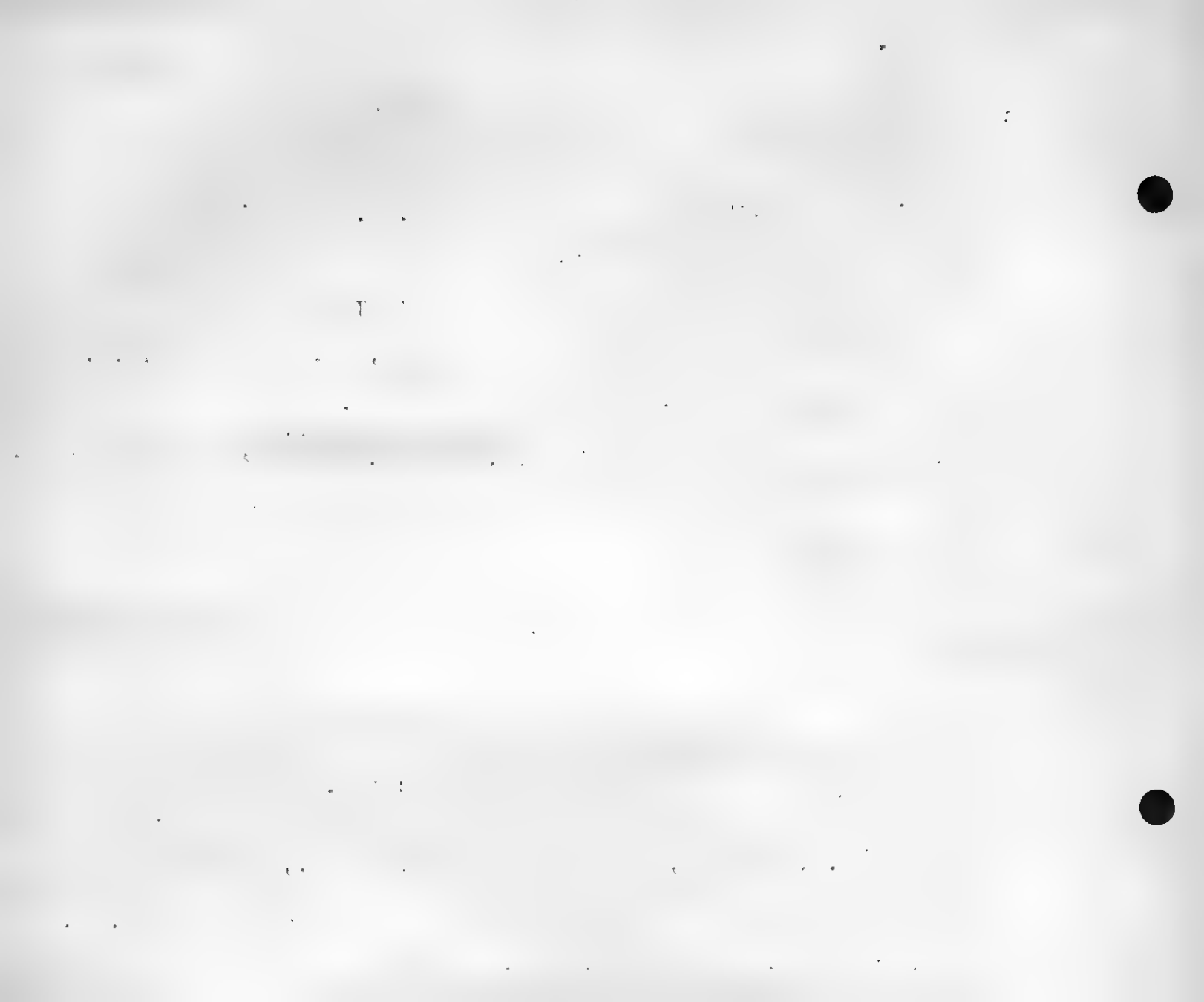
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, 1, MARYLAND

CERTIFICATE OF DEATH

03137

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 48 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS AVE. M. POTOMAC PARK e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) LOWELL ELAINE WIDMYER		4. DATE OF DEATH Month MARCH Day 30 Year 1966		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 17, 1920		9. AGE (In years last birthday) 46 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY Medical Profession				11. BIRTHPLACE (County & State, or foreign country) DOUBS, MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT H. BARTLETT						14. MOTHER'S MAIDEN NAME GRACE E. HOY							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 226-36-6135		17. INFORMANT Rev. George S. Widmyer Address Ave M Potomac Park CUMBERLAND, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Ovary 1500 DUE TO (b) Primary site Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca of Colon resected 1960												INTERVAL BETWEEN ONSET AND DEATH 3 wks	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2/10, 1966 to 3/30, 1966 , that (I) (we) last saw the deceased alive on 3/24, 1966 , and that death occurred on 3/30, 1966 from the causes and on the date stated above.													
22a. SIGNATURE S.G. WEISMAN M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/1/66					
22c. PHYSICIAN'S NAME (Type) S.G. WEISMAN,						22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/2/66		23c. NAME OF CEMETERY OR CREMATORY Greeneway Cemetery				23d. LOCATION (City, town or county) (State) Berkeley Springs, W. Va.			
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.						25a. REC'D BY REGISTRAR APR 5 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge					



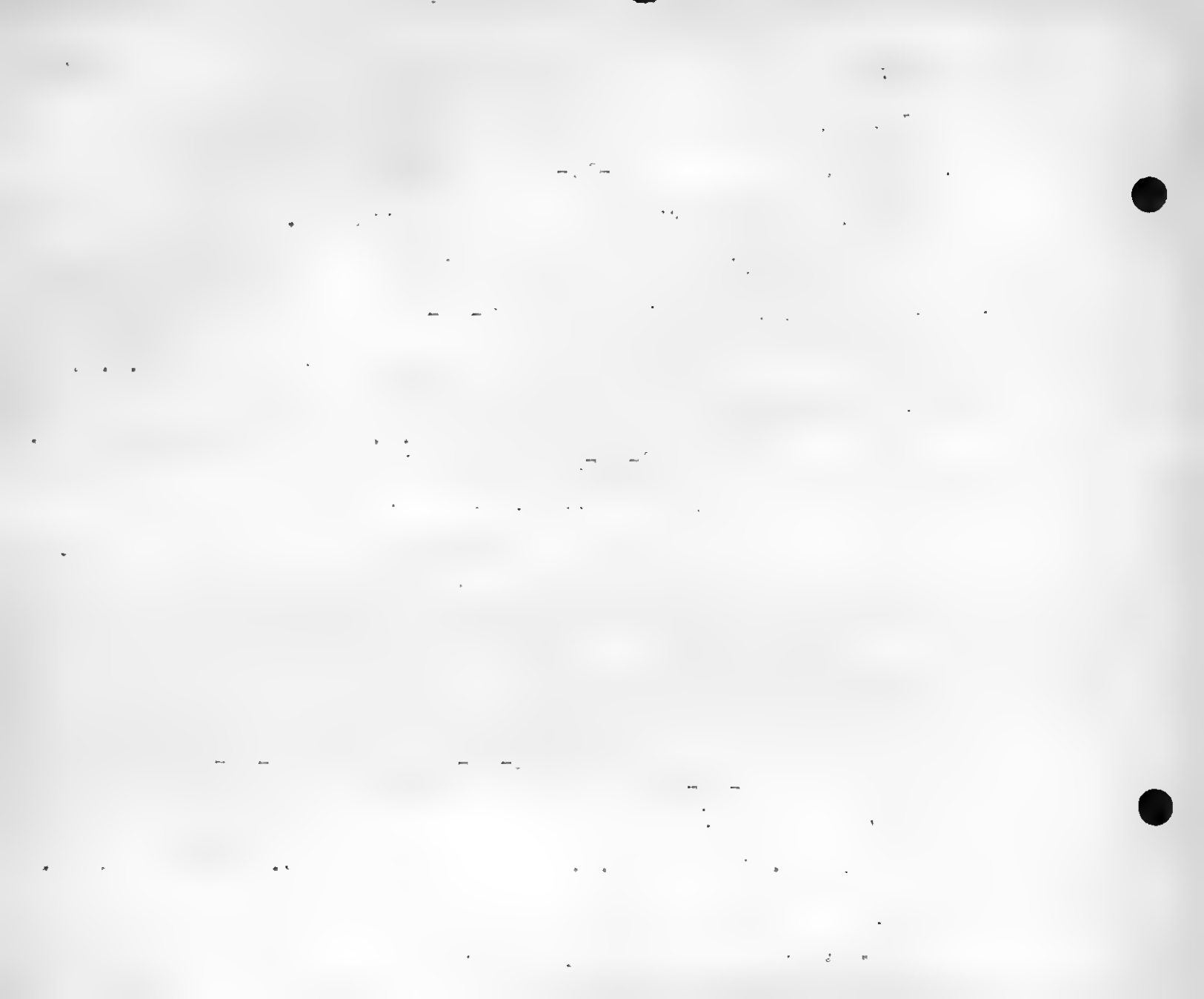
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03153 CERTIFICATE OF DEATH 03138

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		
c. LENGTH OF STAY IN 1b 2-10-66			d. STREET ADDRESS 804 Greene St.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Allegany County Infirmary					
3. NAME OF DECEASED (Type or print) Geraldine Rose Wilson		First Middle Last		4. DATE OF DEATH Month Day Year March 15 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-1886	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegany Maryland	
13. FATHER'S NAME Lewis Francis Wilson		14. MOTHER'S MAIDEN NAME Mary Ann Burnett		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-22-3893A		17. INFORMANT P.O. Box 599 Cumberland, Md. Allegany County Infirmary	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Arteriosclerosis, Coraio Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. disease a Hypertension DUE TO (b) ② "Heart Stroke" (no postlepis) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (i) (this hospital) attended the deceased from 2-10-66 , 19__, to 3-14-66 , 19__, that (i) (we) last saw the deceased alive on 3-14-66 , 19__, and that death occurred Sundat A M , from the causes and on the date stated above.					
22a. SIGNATURE Lee B. Mathews		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M.D.		22d. ADDRESS 49 Greene St. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/17/66	23c. NAME OF CEMETERY OR CREMATORY Mt Pleasant Cemetery	23d. LOCATION (City, town or county) (State) Cumberland Rt 2 Maryland		
24. FUNERAL DIRECTOR Ruth E. Silcox		ADDRESS Cumberland Maryland 21502		25a. REG'D BY REGISTRAR MAR 18 1966 DATE	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03154

03139

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westernport d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Austin Last Wilt				4. DATE OF DEATH Month Mar. Day 14 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1942	
9. AGE (In years last birthday) 23 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Taxi		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Zedick Wilt		14. MOTHER'S MAIDEN NAME Alice Broadwater			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-42-4598		17. INFORMANT Address Delores Wilt-Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE 8254 DUE TO SKULL FRACTURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 77 hours 77 Hours							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto accident					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:30 p.m. Mar. 11 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 220, 2 Mile South Cresaptown, Alleg. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED March 14, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/66		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town or county) (State) Westernport, Md.	
24. FUNERAL DIRECTOR Ed Bral		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR MAR 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03155					03140				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		ALLEGANY			a. STATE		MARYLAND		
		MARYLAND			b. COUNTY		ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
			18 MONTHS		CUMBERLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
SYLVAN RETREAT					619 N. MECHANIC STREET				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First		Middle		Last		Month		Day Year	
CHRISTIAN GROVER		CLEVELAND		ZINK		MARCH		2 1966	
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	
MALE	WHITE	<input checked="" type="checkbox"/>	<input type="checkbox"/>		JULY 29, 1896		79 yrs.	Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Boilermaker - McKaigs Foundry				ALLEGANY, MARYLAND		U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
GEORGE ZINK					MARGARET KNIPP				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT		
No					214-05-8816		Mrs. Pauline Moyer		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					Address 49 N. Mechanic St Cumberland, Md				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					INTERVAL BETWEEN ONSET AND DEATH				
150X DUE TO (1) Myocarditis chr. degenerative Senile									
DUE TO (2) Arteriosclerosis									
DUE TO (3) Carcinoma of Esophagus									
DUE TO (4) 17:11 Senile, psychotic									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from SEPT. 4, 1964, to MARCH 2, 1966, that (I) (we) last saw the deceased alive on MARCH 1, 1966, and that death occurred at 5 A.M. from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
L. B. MATHEWS, M.D.					49 GREENE ST., CUMBERLAND, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		3/4/66		Sunset Memorial Park		Cumberland Rt 3 Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Ruth E. Silcox					Cumberland Maryland 21502		MAR 7 1966		Johnley Judge

00100

00100

00100

00100